NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 14th January 2019

(Held in Public)

15/19 Apologies for Absence

Apologies were received from Mr J Amaechi, Mr N Gower and Mrs G Heaton.

16/19 Declarations of Interest

There were no declarations of interest received for this meeting.

Decision:	Noted	**Action by:** n/a	**Date:** n/a

17/19 Patient Story – 'What Matters to Me'

The Group Chief Nurse introduced a patient story in the form of a DVD clip. The Board did not debate or discuss the clip, preferring to use the story and the imagery to keep the business of the Board focused on the patient experience.

Decision:	Patient Story Received and Noted	**Action by:** n/a	**Date:** n/a

18/19 Minutes of the Board of Directors Meeting held on 12th November 2018

The minutes of the meeting held on the 12th November 2018 were agreed as a correct record.

19/19 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 12th November 2018 and noted progress.

Decision:	Noted	**Action by:** n/a	**Date:** n/a

20/19 Group Chairman's Report

i) The Group Chairman, on behalf of the Board of Directors, congratulated Dr Claire Stevens, Consultant in Paediatric Dentistry at the University Dental Hospital of Manchester, for receiving a CBE in the Queen's New Year's Honours List in recognition of her commitment to improving children's oral health nationally.

ii) The Group Chairman reported that she was delighted to attend an event in December 2018 with Professor Dame Sue Hill, Chief Scientific Officer at NHS England, and, Professor Mark Caulfield, Chief Scientist at Genomics England, to celebrate Greater Manchester's contribution to the 100k Genome Project.

iii) The Group Chairman, on behalf of the Board of Directors, congratulated the following for receiving a number of awards:

- The lung team at Wythenshawe Hospital which won the Acute or Specialist Services Redesign category in the HSJ Awards on 21st November 2018 for their innovative work to enable earlier diagnosis of lung cancer
- The MLCO which won the 'Working Across Systems' award at the HPMA North West awards
- The Research & Innovation Team which won three awards at the Greater Manchester Clinical Research Awards, including a lifetime achievement award for Charles Hay.
- MFT won the Green Champion – for Best Practice in the healthcare sector award recognising Environmental Best Practice at this year's Green Apple Environment Awards, hosted by the Green Organisation.

iv) The Group Chairman, on behalf of the Board of Directors, congratulated Mrs Jayne Bessant who had been successfully elected by the Council of Governors as MFT's **Lead Governor**.

Decision:	Verbal Report Noted	**Action by:** n/a	**Date:** n/a

21/19 Group Chief Executive's Report

i) The Group CEO reported that MFT had received confirmation that it had been chosen as the preferred provider for Trafford Community Services following an external tender process. He explained that the Trust would now commence a due diligence and approvals process and the next stage will be to mobilise a transition team to plan, develop and deliver the mobilisation and transfer agreement.

ii) The Group CEO invited the Joint Group Medical Director to announce that at the end of November, MFT was named as one of a very small number of centres in the UK to offer a revolutionary new cancer treatment (CAR-T), widely regarded as the most exciting cancer treatment development in decades. She explained that the Trust will be able to offer the ground-breaking treatment to children and adults and was unique in this regard.

iii) The Group CEO invited the Group Chief Operating Officer to provide a summary overview of the Trust's contingency plans for a possible *'No Deal EU Exit'*

Decision:	Verbal Report Noted	**Action by:** n/a	**Date:** n/a

22/19 Operational Performance

Board Assurance Report

The Joint Group Medical Director reported that all core priorities for Patient Safety were currently being met with one exception. Attention was drawn to the number of reported Never Events (NEs) experienced within the organisation since April 2018 (n=4) and it was confirmed that a further, more in-depth report would be presented to the Board later on the agenda (under Agenda Item 24/19 – Governance). Dr Benett noted that the organisation's Mortality Data, on a sustained basis, was particularly positive and provided a heightened level of assurance for the Board of Directors.

The Group Chief Nurse reported that whilst the number of new complaints received across the Trust during November and especially December 2018 was down, it was noted that this was consistent with normal variation. The Board was reminded that Complaints performance was monitored and managed through the Accountability Oversight Framework (AOF) alongside the Complaints Scrutiny Group which focused on learning identified (with agreed actions) from individual cases presented by Hospitals/MCSs. The Group Chief Nurse also confirmed that a report on the effectiveness of recording 'Complaints' as a Quality Indicator would be presented to the next meeting of the Quality & Performance Scrutiny Committee in February 2019.

The Group Chief Operating Officer presented an overview of the Trust's operational performance under the key headings of 'A&E 4 hours'; 'RTT'; '+52 Week Waits'; and, 'Cancer 62 Day'. Particular attention was drawn to the ongoing, heightened pressures and challenges within Urgent Care. The Board was advised that MFT's current level of performance was 84.19% (with GM at 83.7%) and ranked as 2nd in GM at the end of December 2018. In response to questions from Mr Rees, the Group Chief Operating Officer described the range of activity and workstreams focused on maintaining patient safety whilst improving flow (it was noted that further details of the MLCO's mobilisation plans with MFT Hospitals/MCS would be presented under Agenda Item 23/19).

The Board noted performance against the Diagnostic standards which was 2.06% in November 2019 and a forecast position of 1.8% for December 2018; which was significantly better than the national position of 3.1%. The Group Chief Operating Officer explained that significant improvement had been achieved in RMCH which was no longer a risk to the standard. However, it was also reported that the organisation faced ongoing demand pressures coupled with workforce challenges in CSS and Adult Endoscopy.

The Group Chief Operating Officer highlighted the Trust's Cancer 62 Day performance against the cancer standard and it was noted that whilst the position remained challenging in the MRI and SMH, strong performance was sustained in WTWA. She also explained that the Trust reported 80.85% against the 85% standard for Q2 (2018/19), with the greatest pressures experienced in Urology and Upper and Lower GI. The Board was advised that a task force with MRI, CSS and the corporate performance team had been established to focus on improving timeliness of pathways, with MRI and CSS taking action to improve capacity as required.

The Group Chief Operating Officer also provided an overview of the Trust's RTT position and confirmed that performance remained static at 89% in November, which was better than the GM and National position. She also explained that the Trust had seen an increase in the RTT waiting list with the national focus for 2018/19 on maintaining the waiting list size by March 2019 compared to the previous year. The Board noted that the Trust was working with Commissioners on demand management and in relation to the +52 week non-RTT breaches, the Trust was reporting 22 breaches in December 2018 (DIEP-only procedures) with a trajectory to be at '0' by end March 2019.

The Group Executive Director of Workforce & OD reported that whilst the Group's attendance rate for November 2018 has increased to 94.8% compared to the previous months figure (94.7%), this was still lower than for the same period the previous last year (95.1%). The Board was advised that in Wythenshawe, Trafford, Withington and Altrincham (WTWA) sites, there had been an emphasis on greater benefits realisation through 'Absence Manager' and the associated benefits of increased data capture and accuracy. It was explained that monitoring of managers compliance in relation to call back and return to work discussions was measured through the 'Absence Manager' dashboards at WTWA Divisional Performance Review meetings. In the MRI, it was reported that weekly scrutiny meetings continued to track absences where a central spreadsheet had been created to record all sickness cases that were not on the absence manager system yet. It was also confirmed that all actions plans had been put in place via the Accountability Oversight Framework.

The Group Executive Director of Workforce & OD described Appraisal performance throughout the Trust which was disappointing. She explained that performance had been deteriorating on a month by month basis compared to the same period the previous year. The Board was advised that in terms of Non-Medical Appraisal performance, this had decreased by 1.1% to 84.8 %. , It was also noted that all Hospitals continued to deliver plans that were presented to the HR Scrutiny committee and had provided assurance that they were still on target to achieve 90% or above compliance by March 2019The Joint Medical Director and Group Executive Director of Workforce & OD teams had put in place a number of actions to ensure that there were no anomalies in the reporting process.

It was also noted that reports continued to be forwarded to Hospital HRDs to support their management teams in planning appraisal activity to redress the negative trend and the Group Deputy Director of Workforce & OD had requested that Corporate Directors also give this matter urgent attention.

The Board Assurance Report was noted as presented.

Decision:	Board Assurance Report noted Report on the effectiveness of recording 'Complaints' as a Quality Indicator to the next meeting of the Quality & Performance Scrutiny Committee	**Action by:** Group Chief Nurse	**Date:** 5th February 2019

<u>2018/19 MFT Emergency Preparedness Resilience and Response Care Standards Self-Assessment</u>

The Group Chief Operating Officer presented the Board o with the MFT self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR).

The Board was advised that the Civil Contingencies Act 2004 and the Health and Social Care Act 2012 underpin EPRR within health. It was explained that both Acts placed EPRR duties on NHS England and providers of NHS funded services.

Mrs Brigewater advised that MFT are a Category 1 responders, which are recognised as being at the core of emergency response and were subject to the full set of civil protection duties including: risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

The Group Chief Operating Officer reported that the minimum requirements Acute Providers must meet were set out in the NHSE Core Standards for EPRRagainst which the Trust must complete an annual self assessment which for 2019-19 was undertaken in October 2018. The assessment comprised key documents of: Statement of Compliance; associated action plan; and, EPRR Core Standards Spreadsheet which outlines the evidence and RAG rating against each individual standard.

The Board was advised that there were a total of 64 standards and additionally each year a 'deep dive' was conducted to gain additional assurance into a specific area. The Group Chief Operating Officer explained that in 2018-2019, the 'deep dive' topic was 'Command & Control' although this does not contribute towards the overall Trust compliance level. There are 4 levels of compliance: Full, Substantial, Partial and, Non-Compliant.

The Group Chief Operating Officer confirmed that following the self-assessment, MFT had declared 'Substantial' compliance which was the same level of compliance as in 2017/18. The Board noted the full statements of compliance as presented in the accompanying report.

In conclusion, the Group Chief Operating Officer confirmed that the Emergency Planning teams were working collaboratively to provide mutual support and expertise to progress against the action plan which would be monitored through the Trust EPRR Group, with external oversight provided through the Local Health Resilience Partnership and Health Economy Resilience Groups.

The Board of Directors noted the contents of the report and the Trust's compliance level.

Decision:	Report and compliance levels noted	**Action by:** n/a	**Date:** n/a

Q3 (2018/19) Transformation Programme Report

The Group Chief Operating Officer provided a summary overview of progress against the Transforming Care for the Future 2018/19 plan and the Trust's continued commitments to achieve the top decile for quality - clinical outcomes, safety, patient experience, staff engagement and operational efficiency measures.

The Board noted the summary of progress against agreed objectives during Q3 (2018/19) under the key headings of 'Continued Sharing of Good Practice via Transform Together'; 'Ensuring the outpatient, elective and SAFER standards are based on best practice'; 'Scaling up areas of best practice across the Group'; 'Monitor Group progress through the AOF'; 'Ensure the patient benefits for year 1 are delivered in line with the KPIs and trajectory approved through the Manchester Investment Agreement'; 'Ensure implementation of the first phase of the general surgery Healthier Together consolidation'; 'Working with OD to ensure high performing team principles underpin key activities'; 'Work with Finance and Turnaround to ensure the clinical benefits derive financial benefits as outlined in the Business Case and PTIP'; 'Continue to commission leadership and improvement courses to meet the needs of staff'; and, 'continue to work with the Clinical Standards Groups (CSGs) and clinical teams to continue to generate ideas and translate into practice'.

The Group Chief Operating Officer also drew attention to several of the key objectives and delivery trajectories outlined within the Transformation Programme for Q4 (2018/19).

The Board noted the report as presented.

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

Progress Report on the Single Hospital Service

The Director of the Single Hospital Service provided an update on the Single Hospital Service (SHS) Programme. Particular attention was drawn to the development of Integration Plans and continued governance arrangements (including the key areas of focus for the Integration Steering Group chaired by the Director of the Single Hospital Service). It was noted that as intended at this stage of the merger, year two integration plans were being developed with direct contributions from corporate, operational and clinical teams. It was also noted that this included attention to the implementation of complex programmes of work aimed at harmonising care pathways.

The Director of the Single Hospital Service confirmed that the fifth iteration of the Post Transaction Integration Plan (PTIP) was nearing completion and was aimed at refreshing and reinforcing integration plans going forward to ensure that MFT realised and tracked merger benefits. It was noted that the Board of Directors would be briefed further on the scope and content of the PTIP in February 2019. The Director of the Single Hospital Service and the Group Executive Director of Strategy also confirmed that all of the integration planning highlighted remained closely connected to the development of the MFT clinical service strategy and this included a focus on implementation plans for improvements to clinical services. It was also noted that this work was clinically led which is generating positive clinical engagement.

The Director of the Single Hospital Service reported that good progress continued with the Integration Programme, details of which were provided and noted by the Board in the accompanying year one post-merger report. It was also noted that the report explained the scale and breadth of achievements made and set out a high level account of lessons learnt. The Board acknowledged that as a consequence of the efforts made by all staff, MFT had an even firmer platform to begin to operationalise large, complex schemes to promote additional patient and organisational benefits. Extracts from the report which illustrated the type of patient benefits MFT had achieved in the first year of the merger were also noted.

The Director of the Single Hospital Service provided an overview of the delivery of the Manchester Investment Agreement patient benefits which was reported to Manchester Health and Care Commissioners (MHCC) on a quarterly basis. It was noted that MFT was held to account by MHCC on the delivery of specific, measurable patient benefits such as shorter wait times to surgery and improved clinical outcomes. It was anticipated that a further cohort of metrics would be included in the agreement as part of a process to review and re-baseline deliverables that MFT would seek to realise over the coming two years.

The Board received an update on NHS I's proposal for MFT to acquire NMGH as part of an overall plan to dissolve PAHT and transfer the remaining hospital sites to Salford Royal Foundation Trust (SRFT). The Director of the Single Hospital Service explained that the intention for MFT to acquire NMGH was consistent with the local plan to establish a Single Hospital Service within the City of Manchester and formed part of the Manchester Locality Plan.

The noted that the transaction process was being managed under the auspices of the national NHS I Transaction Guidance with oversight provided by a Transaction Board established at the end of November 2017. The Director of the Single Hospital Service explained that one of the challenges in completing this work was the need to ensure the strategic cases submitted by SRFT and MFT were complementary i.e. not contradictory or in any way inconsistent with the two-lot proposal. In this context, the Director of the Single Hospital Service went on to explain that MFT continued to work collaboratively with MHCC, PAHT, SRFT, and NHS I and colleagues at GMH&SCP to ensure the two transactions associated with the dissolution of PAHT were progressed as efficiently as possible.

The Board was advised that in anticipation of the proposed transaction, MFT and MHCC continued to engage with colleagues at NMGH through a staff engagement programme.

In conclusion, the Director of the Single Hospital Service explained that the integration work was progressing well aimed at realising patient benefits and creating new efficiencies. He re-confirmed that the year one post-merger report provided a good account of this work and illustrated the criticality of the Post Transaction Integration Plan to ensuring integration objectives stayed on track.

The Board also noted the importance of integration notwithstanding, MFT remained committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT at the earliest practicable opportunity. On this basis, the Board re-confirmed that MFT would continue to engage with all key stakeholders and in particular, work with Greater Manchester Health and Social Care Partnership in its role to oversee the plan to dissolve Pennine Acute Hospitals NHS Trust.

The Board noted the content of the report.

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

Group Chief Finance Officer's Report

The Group Chief Finance Officer provided an overview of his Month 9 (2018/19) report.

The Board noted that the consolidated financial performance at Month 9 was a bottom line deficit (on a control total basis excluding Provider Sustainability Fund) of £12.4m (1.0% of operating income). The Group Chief Finance Officer provided a summary overview of the organisation's Q3 (2018/19) delivery improvement trajectories and performance. He explained that the cumulative position at 31st December 2018 was £8.5m worse than forecast (comparing forecast versus actual) with particular attention drawn to key pinch-points in Trading Gap savings plans; non-pay rate of expenditure; medical workforce expenditure; nurse bank and agency spend; and, elective income.

Both the Group CEO and the Group Chief Finance Officer particularly emphasised that significant improvement in Hospital financial results over the fourth quarter of the year was required to avoid leaving delivery of the year end control total in an extremely challenging position and potentially losing eligibility for over £11m of remaining PSF funding.

Particular attention was drawn to a range of workstreams focused on improving the organisation's financial performance including the continued embedding of 'Turnaround' and 'Transformation' team support within key areas (as described previously under agenda the Q3 Transformation Update Report); fast tracking business cases that impacted favourably on run-rate; providing Procurement support to manage additional non-pay controls; input from the Group Chief Nurse and Joint Medical Directors into Hospital/MCS Executive Team meetings; and, targeted Workforce & OD support where performance indicators were challenged.

The Group Chief Operating Officer also described increased opportunities for shared learning across other Hospitals/MCSs within the Group. Examples provided included the sharing of 'good practice', tools and techniques between the WTWA and MRI Medical Directors in addressing ongoing challenges within the Medical Workforce in key areas such as Job Planning & Rotas.

The Board was also reminded by the Group Chief Operating Officer that the *'Confirm & Challenge'* meetings had continued to be held with each individual Hospitals/MCS leadership team to monitor their intervention and improvement plans, within a clear accountability framework. She also confirmed that there was a very clear maturity of understanding throughout each of the Hospital/MCS leadership Teams of their individual and collective accountabilities and responsibilities coupled with an appetite for change.

In response to questions from Dr Benett regarding the emphasis on preserving the organisation's heightened levels of Patient Safety & Outcomes during the current financial challenge, the Group Chief Finance Officer and Group Chief Nurse reminded the Board of the organisation's well-established 'Quality Impact Assessment Framework' and it's continued application when developing, assessing and implementing efficiency saving schemes and work-programmes.

The Group Chairman confirmed that further 'deep-dives' and heightened levels of challenge would be undertaken at the next meeting of the Board of Director's Finance Scrutiny Committee scheduled for 23rd January 2019.

The Chief Finance Officer's Month 9 Report was noted.

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

23/19 Strategic Review

Update on Key Strategic Developments

The Group Executive Director of Strategy provided an update on a range of key strategic issues which were currently being progressed. Particular attention was drawn to the alignment of NHS England and NHS Improvement and it was confirmed that appointments had been made to the majority of the posts at a national level and to the Regional Director posts. It was noted that Mr Bill McCarthy had been appointed as the North West Regional Director, which covered Greater Manchester (expected start-date – February 2019). The Board noted the further details of all appointments set out in the accompanying attachment to the report as presented.

The Group Executive Director of Strategy also reported that NHS E and NHS I had published the first part of the 2019/20 operational planning guidance on 21st December 2018. He explained that the guidance was not complete and the full guidance was expected in January 2019 alongside the NHS long term plan. It was noted that the guidance signalled a greater focus on system planning, with system plans to be submitted and system control totals to be set for each Integrated Care System and Sustainability Transformation Partnership. The Board also noted that for MFT, it was expected this would mean a Greater Manchester level control total.

The Board also received a summary overview of the proposed models of care for the *Theme 3* projects which had now been endorsed by the GM Joint Commissioning Board and would proceed to the next stage which was the modelling work that the partnership was undertaking, supported by McKinsey. The Group Executive Director of Strategy described the *Theme 3* projects which included a new single Upper GI Surgical service for Greater Manchester which was based at Salford NHS FT and had now been formally launched.

The Group Executive Director of Strategy described some of the key components of MFT's Service Strategy Development. Particular attention was drawn to the first version of the Group Service Strategy which had now been approved by the Board. It was noted that a programme had been developed to engage with a wider audience, both internally and externally, on the key messages. The Group Executive Director of Strategy explained that the document would continue to be iterated over the next six months to take account of any issues arising through the development of the individual Clinical Service Strategies for Wave 2 and 3 services and the Managed Clinical Services (Children's services, Women's services, Eye services and Dental services). It would also take account of feedback received through the engagement process.

The Board received an overview of the development of the draft Clinical Strategy documents which had been completed for all of the Wave 1 clinical services. It was noted that further work was being undertaken to assess the impact of any service changes proposed within the strategies in terms of resources and capacity.

The Group Executive Director of Strategy explained that any site-specific proposals or proposals for major service change were at a formative stage and a decision to make or implement any material service changes would not be taken until after Trust and/or Commissioners had taken appropriate steps that may (as required) include public involvement, consultation with the relevant Health Overview Scrutiny Committee(s) and the completion of an equality impact assessment.

The Board was advised that Workshops for the Wave 2 services and the Managed Clinical Services (Children's, Eye and Dental) had commenced and it was expected that the strategies for the Wave 2 services would be completed in February 2019 and that the strategies for the Wave 3 services and the MCSs would be completed during April / May 2019.

Board noted the report and in particular the announcement of the new combined NHS I/NHS E leadership roles and appointments; the updates on the GM Theme 3 transformation and implementation programmes; and, progress on the development of the MFT overarching group service strategy and the individual clinical service strategies.

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

Update on the Manchester Local Care Organisation (MLCO)

The Chief Executive (MLCO) provided an update report paying particular attention to several key areas, namely, MLCO System Escalation; New Care Models; MLCO Roadmap Planning; and, MFT Scrutiny Committee.

The Board was reminded that alongside leading the programmes of work bringing together health and social care services and delivering transformation activity, the MLCO was working closely with MFT to support local people by working to prevent the need for admission to hospital wherever possible, and, getting people home from hospital in a timely and safe manner when they do need hospital care.

The Chief Executive (MLCO) explained that with support from partners, including Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust, there had been an initial period of focussed activity to support people who had faced a long length of stay in hospital.

The Board was advised that to date, this work had focussed predominantly on the pressures at the Manchester Royal Infirmary with the MLCO senior leadership working closely with colleagues to expedite the movement and discharge of patients from an acute to the most appropriate community setting. The Chief Executive (MLCO) and Group Chief Operating Officer confirmed that as at 14th December 2018, the programme of work led by the MLCO had supported the discharge of 91 patients with an accumulated length of stay of circa 9,750 days. He also explained that this programme of work, which had been operational for 3 months, had supported the average length of stay at the MRI which had decreased by 5 days, indicating the impact this was having on acute flow, as well as ensuring that patients were treated in appropriate community settings and home where possible.

In response to observations by the Group CEO, the Chief Executive (MLCO) confirmed that in order to support the programme of work being developed across the City, the MLCO was working collaboratively with Partners as part of the winter resilience programme. He provided an overview of several schemes which had been identified, including the establishment of a citywide control centre. The Board noted that it was planned that this would build on the approach to date and support a wider coverage across the City and that it was in addition to the mobilisation of new care models.

Attention was also drawn to the New Care Models (NCM) which the MLCO was responsible for mobilising and continued to progress through the key phases of business case, design, mobilisation, implementation and evaluation. It was noted that the priority for 2018/19 was threefold and a detailed update was provided against each of the programmes, namely, Integrated Neighbourhood Teams; Manchester Community Response; and, High Impact Primary Care.

The Chief Executive (MLCO) provided a brief overview of the MLCO's Roadmap Planning along with the key areas of focus at the MLCO Scrutiny Committee meetings. He also explained that the MLCO would realise its full potential in a three year phased approach. The Board was reminded that the majority of services that were transferred in year one were community health services (including North Manchester Community Health Services) and directly provided Adult Social Care. The Chief Executive (MLCO) explained that year two would see a range of other services move under the management of MLCO including a host of commissioned services such as Home Care and Residential and Nursing Care. The Board was advised that the MLCO was now in the process of developing a range of road maps that would support the development and growth of the organisation to enable it to realise the potential that was outlined in the original prospectus.

The Board noted the contents of the update report as presented by the Chief Executive (MLCO).

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

24/19 Governance

Progress Report on the Gosport Improvement Programme

The Joint Group Medical Director provided a progress report on the Gosport Improvement Programme. She reminded the Board of the key headlines captured in the original report presented in September 2018 setting out the main findings and an analysis of the position at MFT in respect of the potential for this practice to have arisen in the past or in the future.

The Board recalled that the previous report set out a number of Group wide actions and the monitoring arrangements going forward and the Joint Group Medical Director confirmed these were now noted in the report as presented. She also reported that Hospitals and MCS had all undertaken a self-assessment and review, and, a summary of progress was now noted for the Manchester Royal Infirmary; Wythenshawe, Trafford, Withington and Altrincham; Royal Manchester Children's Hospital; Saint Mary's Hospital; and, Clinical and Scientific Services.

The Board of Directors noted progress with the Gosport Improvement Programme and it was agreed that a follow-up report would be prepared in the Summer 2019 to provide assurance that there were no on-going areas of concern.

Decision:	Update report noted Follow-up report on the Gosport Improvement Programme to be provided in the Summer 2019,.	**Action by:** 8th July 2019	**Date:** Joint Group Medical Director

Update Report on 'Never Events'

The Joint Group Medical Director presented an update report on 'Never Events' (NE) and reminded the Board that NEs were defined nationally as incidents which are wholly preventable. She also reminded the Board that 'serious harm' did not need to have occurred for an event to be defined as a NE and many of these events resulted in low, or, no harm to patients. It was also noted that NE were included on the MFT Accountability Oversight Framework (AOF) under the Patient Safety section.

The Joint Group Medical Director reported that there had been eight NEs reported since the merger in October 2017 and four of these had been since April 2018. She also pointed out that in that same time period, a total of 294 NEs were reported nationally with 25 organisations reporting four or more during this period (details noted as presented in the report).

The Board received an overview of the NEs reported in 2018/19 which included two misplaced naso-gastric (NG) tubes within Intensive Care setting; a wrong device implanted (right instead of left wrist plate); and, a wrong side anaesthetic block. Further details of each of the NEs described were noted in the report as presented.

In response to questions from Dr Benett, the Joint Group Medical Director confirmed that root cause analysis investigations had been undertaken for each incident along with details of the levels of harm and the Board noted the summary table highlighting key findings, and range of actions and recommendations for each event. Particular attention was drawn to the key recommendations which were focussed on reviewing Safe Surgery, Sedation and Consent policies, review of risk assessments, development of Local Safety Standards for Invasive procedures and education and awareness raising across the Trust.

The Joint Group Medical Director also confirmed that a draft policy for Safe Procedures was currently with Hospital Sites/MCS for comments with a plan to ratify in January 2019.

The Board noted that following the recent NEs, the risk score had been reviewed and all Hospital sites / MCS had undertaken detailed risk assessments, including current controls and any gaps against all NE types. The Joint Group Medical Director explained that learning from NE incidents had been shared across the organisation and included internal safety alerts and a range of articles in Safety Matters @MFT and Safety One Liners. It was also explained that Hospital/Managed Clinical Service Medical Directors had agreed at the September 2018 MD Forum to champion dissemination of learning from NEs as well as other measures to raise awareness and reduce risk of recurrence.

The Board noted the information and the actions planned to mitigate risk of recurrence and it was agreed that an update report would be provided on progress with actions in 6 months.

Decision:	Update report noted Update report on progress with Never Events actions in 6 months.	**Action by:** 8th July 2019	**Date:** Joint Group Medical Director

Update Report on the Flu Vaccination Programme and Management of Flu Activity

The Group Chief Nurse and Group Executive Director of Workforce & OD provided an update on progress of the key activities and developments in the management of patients with flu and the staff flu vaccination programme for the 2018/2019 season.

The Board noted the background to the activation of the Flu vaccination programme(s) and the additional actions implemented to facilitate patient flow within MFT from January 2018 (previously reported to the Board of Directors). The Group Chief Nurse explained that following on from the lessons learned during the previous season, a programme of actions had been implemented in order to ensure that MFT was prepared for this year. She confirmed that the management plan had been prepared in advance of the 2018/19 flu season and approved by the Group Infection Control Committee. The range of actions highlighted was noted by the Board as presented.

The Group Chief Nurse highlighted the number of new cases of flu for the 2018/19 season (to date) captured within the report and explained that there were currently 40 patients with flu in MFT Hospitals/MCSs. It was also noted that whilst there had been 10 more cases reported for December 2018 at the Oxford Road Campus compared to December 2017, it was likely this was attributable to an increase in the number of samples tested.

The Group Executive Director of Workforce & OD reported that in September 2018, NHS employers and NHSI set out recommendations for this year's flu programme. She explained that MFT had reviewed the best practice management checklist, required to provide public assurance and had confirmed that the organisation was meeting each element of best practice.

The Board recalled that planning for this year's campaign had started prior to the summer and a key component on the plan was to make the vaccination programme as accessible and engaging to all staff across the Trust. Attention was drawn to the development and deployment of a group communication plan utilising all available media channels with a formal launch of the programme by the Group Chief Nurse on the 1st October 2018. The Board also noted that over 170 flu champions had been recruited and trained and all MFT hospitals had delivered pop-up clinics which were promoted locally and in Group-wide communications.

The Group Executive Director of Workforce & OD reported that the uptake of Flu Vaccination by MFT Healthcare Care Workers (to date) was 10% higher than the previous year and currently stood at 13,112 (61%). However, it was recognised that this was approximately 11% short of the expected target and heightened levels of communication and activity was underway to meet the expected 75% target by the end of March 2019.

In conclusion, the Board noted that nationally and locally the 2017/18 flu season was the most challenging since the pandemic of 2010/11. It was also noted that expectations was that the 2018/19 season would not be as severe, however, lessons learned from the previous year had been identified and incorporated into the management plans for patients with influenza in 2018/19 to facilitate a proactive approach as far as is possible.

It was also recognised that there were challenges identified from the staff flu vaccination programme for 2017/18 following the creation of MFT in October 2017 as both predecessor organisations had initially developed separate plans for the delivery of the 2017/18 programme. However, it was also recognised that this year, there had been a unified approach, led by the EHW service based on the lessons learned from last year.

The Board noted the Trust's plans and performance to date for the 2018/2019 flu season.

Decision:	Update Report noted	**Action by:** n/a	**Date:** n/a

Note Committee meetings which had taken place:

- Group Risk Management Committee held on 5th November 2018
- Audit Committee held on 7th November 2018
- Finance Scrutiny Committee on 22nd November 2018
- Quality & Performance Scrutiny Committee on 3rd December 2018
- Charitable Funds Committee held on 12th November 2018
- MLCO Scrutiny Committee held on 14th November 2018
- HR Scrutiny Committee held on 18th December 2018

25/19 Date and Time of Next Meeting

The next meeting of the Board of Directors held in public will be on **Monday 11th March 2019** at **2pm** in the **Main Boardroom**

26/19 Any Other Business

There was no other business.

Present:	Professor Dame S Bailey	- Group Non-Executive Director
	Mr D Banks	- Group Director of Strategy
	Dr I Benett	- Group Non-Executive Director
	Mrs J Bridgewater	- Group Chief Operating Officer
	Mrs K Cowell (Chair)	- Group Chairman
	Mr B Clare	- Group Deputy Chairman
	Sir M Deegan	- Group Chief Executive
	Professor J Eddleston	- Joint Group Medical Director
	Professor L Georghiou	- Group Non-Executive Director
	Mrs M Johnson	- Group Director of Workforce & OD
	Professor C Lenney	- Group Chief Nurse
	Mrs C McLoughlin	- Group Non-Executive Director
	Miss T Onon	- Joint Group Medical Director
	Mr T Rees	- Group Non-Executive Director
	Mr A Roberts	- Group Chief Finance Officer
In attendance:	Mr P Blythin	- Director Single Hospital Service
	Mr D Cain	- Deputy Chairman Fundraising Board
	Mr M McCourt	- Chief Executive, MLCO
	Mr A W Hughes	- Director of Corporate Services/Trust Board Secretary
Apologies:	Mr J Amaechi	- Group Non-Executive Director
	Mr N Gower	- Group Non-Executive Director
	Mrs G Heaton	- Group Deputy CEO

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 12th November 2018			
Action	Responsibility	Timescale	Comments
Progress report on the continued development of the MFT BAF	Group Executive Director of Workforce & OD	11th March 2019	*Scheduled*

Board Meeting Date: 14th January 2019			
Action	Responsibility	Timescale	Comments
Report on the effectiveness of recording 'Complaints' as a Quality Indicator to the next meeting of the Quality & Performance Scrutiny Committee	Group Chief Nurse	5th February 2019	*Scheduled*
Follow-up report on the Gosport Improvement Programme to be provided in the Summer 2019,.	Joint Group Medical Director	8th July 2019	*Scheduled*
Update Report on progress with Never Events actions	Joint Group Medical Director	8th July 2019	*Scheduled*

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Gareth Summerfield, Head of Information, Information Management, CMFT
Date of paper:	January 2019
Subject:	Board Assurance Report
Purpose of Report:	Indicate which by ✓ • Information to Consider ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust.
Recommendations:	The Board of Directors is asked to Consider the content of the report
Contact:	Name: Gareth Summerfield, Head of Information Tel: 0161 276 4768 E-mail: Gareth.Summerfield@cmft.nhs.uk

Manchester University NHS Foundation Trust

> Board Assurance

January 2019

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	4	0	2	0

Headline Narrative

Core priorities for patient safety are currently being met with one exception. The Group has had a number of Never Events reported over the last 12 months. Since April 2018 there has been four reported events.

In response to this the following actions are underway and will be included in a review of the group risk (Never Events - 3228).

- New MFT Policy in place for Safe procedures and being implemented
- Group wide work is being undertaken on Safe Surgery/Procedure Checklists
- Work is being undertaken with the National Health Safety Investigation Branch (HSIB) on learning
- Work is being undertaken with the Shelford Safety leads to ascertain if there is further learning and action that can be shared
- A further Safety Alert has been circulated to all Hospital sites with required actions

-All Hospital Sites / MCS are undertaking risk assessment for each Never Event typeincluding identifying controls in place and actions required and adding to the Risk Register
The Quality and Safety Committee will be overseeing this work and the aim continues to be to eradicate these events.

Serious harm incidents so far this year are just above the threshold compared with same period last year.

Mortality Metrics at Group level continue to be within accepted performance level and improving over time. Mortality Review procedures are under review and awaiting National guidance before finalising.

Safety - Core Priorities

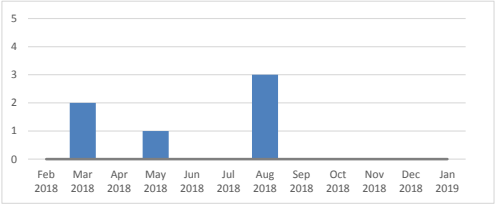
Never Events

MFT

✕

Actual	4	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✓	✓	✓	✓	✓	✕
3	0	0	0	0	0	1

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed. The list is determined nationally.

Since April there have been 4 Never Events 2 misplaced NG Tubes in critical care areas, 1 wrong site surgery and 1 wrong implant. Investigations for all of these are complete with a range of actions being implemented.

Actions

Working groups are reviewing local risks and implementing solutions to reduce harm with the ongoing implementation of Local Safety Standards for Invasive Procedures (LocSSIPs).
The never events risk is under review.

Progress

Following these events a number of immediate actions were implemented including issuing of Trust wide alerts. Investigations have been undertaken to identify learning with associated action plans in place. In addition we are working with the Healthcare Safety Investigation Branch on the wrong route medication Never Event to contribute to national learning and solution development.

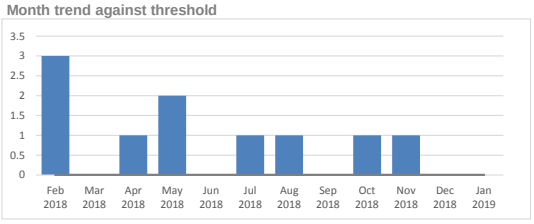
A new MFT Safe Procedure Policy is now in place. Further work is now being undertaken Group wide on safer surgery/ procedure checklists and item counts, this work will be reported to the Quality and Safety Committee.

Mortality Reviews - Grade 3+ (Review Date)

MFT

Actual	7	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✓	✓	✓	✗
1	1	1	0	0	0	4

The number of mortality reviews completed where the probability of avoidability of death is assessed as definitely avoidable.

Key Issues

Since the inception of MFT in October 2017, a considerable amount has been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care.

The role of the Group Mortality Review Group in supporting dissemination of good practice, lessons and action plans is being developed. Mortality review processes are generally robust, but will be altered by the introduction of a Medical Examiner system. A deficiency in mortality review for patients with learning disability has been identified, and a new process commenced.

Overall, mortality metrics suggest that the work programs of 2017/2018 to address coding issues have been successful, but that co-morbidity coding requires further work.

Actions

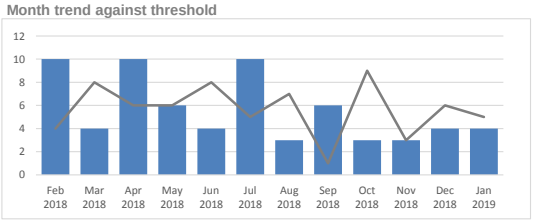
The creation of MFT has provided an opportunity to re-evaluate the approaches to learning from deaths in both organisations, and to implement a new policy based on national guidance and best practice in both organisations. Going forward, the focus will be on learning from deaths, and dissemination of the resulting changes and developments in practice across the organisation.

Hospital Incidents level 4-5

MFT

Actual	53	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	56	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✗	✗	✓	✓	✓
3	15	5	9	0	0	21

This is a broad, all embracing category covering incidents at a high level e.g. falls, pressure ulcers, medication errors etc. (These figures include incidents that are unconfirmed so may decrease)

Key Issues

Serious harm (level 4 & 5 actual harm incidents). The organisation continues to report high numbers of patient safety incidents per 1000 bed days, (Central and Trafford site hospitals 57.69 and Wythenshawe Hospital 55.54) in the last NRLS data report. This indicates a willingness to report and learn (an assumption supported by the staff survey results). Over 99% of these incidents are low level harm or no harm incidents.

The overall number of serious harm incidents ytd compared to the same period last year is at a similar level. In terms of hospital sites the threshold is based on the same period last year and it can be seen that a small increase has been observed, however these are small numbers and natural variation will occur and a number of these remain unconfirmed. In addition as services change / reconfigure this may impact on this method. Therefore alternative approaches to this are being considered.

Actions

Communication of test results remains a focus across the Group and work is underway to further develop the clinical risk plan in respect of communication and response to clinical tests.

Thematic reports are reviewed at a number of forums and will inform the 19/20 work plans.

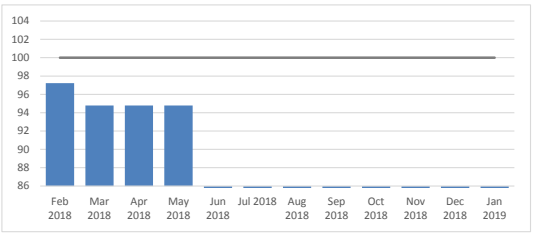
> Board Assurance

January 2019

SHMI (Rolling 12m)

MFT

Actual	94.8	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	96.0	NA	NA	NA	NA	92.4

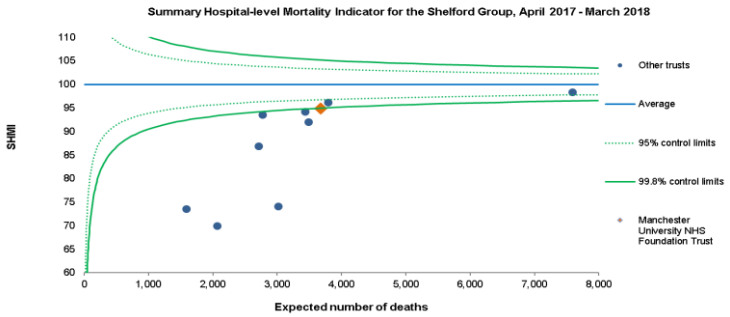
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline.

Progress

The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review process and establishing the Medical Examiner role. This guidance is under review and will inform the revised Strategy.

SHMI is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded). Risk adjusted mortality indices are not applicable to specialist children's hospitals. All child deaths undergo a detailed mortality review.

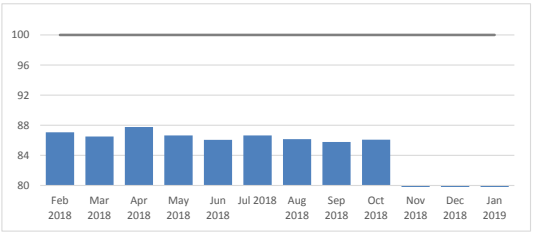
Performance is well within the expected range.



HSMR (Rolling 12m)

MFT

Actual	86.1	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	82.3	NA	NA	NA	NA	85.6

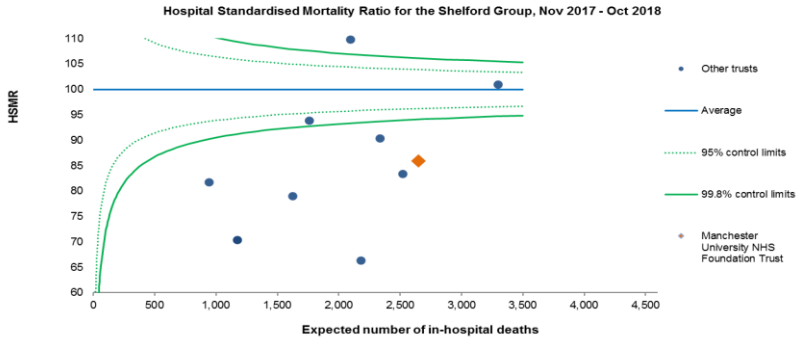
HSMR monitors a Trust's actual mortality rate when compared to the expected mortality rate. It specifically focuses on 56 diagnosis codes that represent 85% of national admissions.

HSMR is a metric designed for adult practice.
Risk adjusted mortality indices are not applicable to specialist children's hospitals. All child deaths undergo a detailed mortality review
HSMR is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded)

The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review process and establishing the Medical Examiner role. This guidance is under review and will inform the revised Strategy.

Progress

The Group HSMR is within expected levels.



> Board Assurance

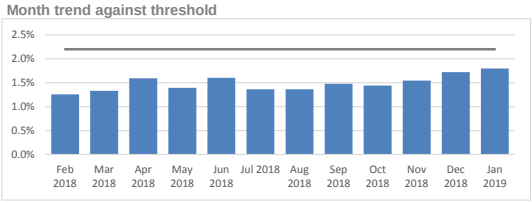
January 2019

Crude Mortality

MFT

Actual	1.53%	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	✓	◇
NA	1.9%	0.2%	0.3%	0.1%	0.0%	2.4%

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period.

Key Issues

Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment.

For the Crude Mortality the latest figures are within acceptable range.

Progress

The Trust is currently reviewing Elective crude mortality which whilst still low has increased in the quarter.

There is currently consideration being given to mortality metrics in RMCH, deaths per 1000 bed days will now be reported to allow for additional benchmarking with other specialist children's hospitals.

Patient Experience

C.Lenney

Core Priorities	✓	◇	×	No Threshold
	4	1	2	2

Headline Narrative

The number of new formal complaints received across the Trust during January 2019 was 120; compared to 79 in December 2018 and 117 in November 2018. Performance is monitored and managed through the Accountability Oversight Framework (AOF). At the end of January 2019 there was a total of 55 cases over 41 days old, compared to 49 cases at the end of December 2018 and 51 cases at the end of November 2018, which reflects an relative similar position. The overall number of formal complaints and PALS concerns received has been adjusted this month to includes data for MLCO. The percentage of complaints resolved within the agreed timeframe with complainants continues to significantly underperfom.

Extensive work has been undertaken during 2017/18 to develop and align complaints/PALS systems and processes and accountability for specific aspects of complaints management has been devolved to Hospital Chief Executives and Directors of Nursing/Midwifery.

MFT continues to promote the Friends and Family Test (FFT) with an improved score of 94.84% of respondents 'Extremely Likely' or 'Likely' to recommend the service they received to their Friends and Family during January 2019, this compares to 93.2% in December 2018 and 92.8% in November 2018. This is the second highest score since April 2018.

Infection prevention and control remains a priority for the Trust. The total number of attributable bacteraemias in January 2019 was 13, increasing from 10 in December 2018. The threshold for bacteraemias remains zero. C. difficile lapses in care remain below the Trust's threshold with 31 cases since April 2018 compared to a year to date threshold of 85 cases.
At the end of January 2019 there were 16 (14%) inpatient wards across the Group that had a registered nurse vacancy factor above 25%The nurse fill rate has continued to improve month on month since August 2018 when it was 80.6%.

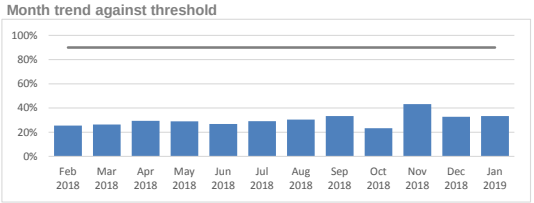
Patient Experience - Core Priorities

Percentage of complaints resolved within the agreed timeframe

MFT

Actual	30.9%	Year To Date	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
×	×	×	×	×	×	×
35.4%	17.2%	26.6%	31.8%	44.6%	39.5%	39.8%

The Trust has a responsibility to resolve complaints within a timeframe agreed with the complainant. The timeframe assigned to a complaint is dependent upon the complexity of the complaint and is agreed with the complainant.

Progress

The percentage of complaints resolved within the timeframe agreed with the complainant is closely monitored and work is on-going with Hospital/MCS management teams to ensure timeframes are appropriate, agreed with complainants and achieved.

The overall MFT performance for January 2019 was 33.3% compared to 32.8% in December and 43.2% in November 2018.

In July 2018 the closure of complaints within the agreed timescales at Manchester Royal Infirmary (MRI) was 13.9%. The issue was identified, therefore an improvement programme was developed with an agreed trajectory for improvement. Closure of cases within agreed timeframe at MRI was 37.1% in November 2018, 16.3% in December 2018 and 17.1% in January 2019, demonstrating a slight improvement from December 2018 to Janaury 2019, in the closure of complaints within the agreed timescales.

The Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart. It should be noted that where Hospitals/MCS receive lower numbers of complaints, small numbers can result in high percentages.

Actions

Performance is monitored and managed through the Accountability Oversight Framework (AOF).
MRI is currently receiving additional supported from the Corporate Team to increase compliance with this indicator.

> Board Assurance

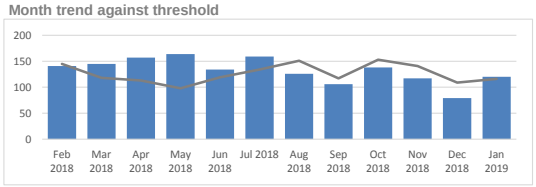
January 2019

Complaint Volumes

MFT

Actual	1300	Year To Date	**Accountability**	C.Lenney
Threshold	1251	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✗	✓	✗	✓
71	374	135	158	55	41	365

The KPI shows total number of complaints received. Complaint volumes will allow the trust to monitor the number of complaints and consider any trends.

Key Issues

The number of new complaints received across the Trust in January 2019 was 120. This compares to 79 in December 2018 and 117 in November 2018.

WTWA received the highest number of formal complaints in January 2019 with 34. This number is higher than the number received by WTWA in December 2018 (19) and November 2018 (27).

At the end of January 2019, there was a total of 55 cases over 41 days old, this compares to 49 cases at the end of December 2018 and 51 cases at the end of November 2018. The Hospital/MCS with the highest number of cases over 41 days at the end of December 2018 was MRI with 19 (38.8% of total) cases at 41 days old.

Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart.

Actions

All Hospitals/MCS continue to prioritise closure of complaints older than 41 days. Chief Executives are held to account for the management of complaints cases that exceed 41 days through the Accountability Oversight Framework. MRI is currently being supported by the Corporate Nursing team to expedite the effective closure of complaints older than 41 days.

Progress

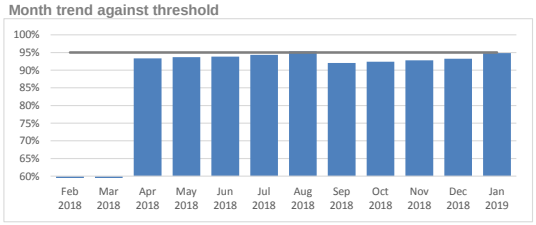
All Hospitals/ MCS have established their governance frameworks to focus on the management of complaints, specifically those that exceed 41 days with a view to expediting closure and identifying learning to inform future complaints prevention and management.

FFT: All Areas: % Extremely Likely and Likely

MFT

Actual	93.6%	Year To Date	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	◇	✓	✓	✓	◇
98.0%	89.6%	94.5%	97.9%	97.2%	97.3%	92.3%

The Friends and Family Test (FFT) is a survey assessing patient experience of NHS services. It uses a question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, a person is to recommend the service to a friend or family member if they needed similar treatment. This indicator measures the % of inpatients 'extremely likely' and "likely" to recommend the service.

Actions

Each Hospital/Managed Clinical Service reviews and monitors of FFT response rates and patient feedback to identify any areas for improvements in order to increase response rates and act upon the feedback received.

The Quality Improvement Team and Patient Experience Teams are working with our provider for patient experience and Hospitals / MCS to support consistent collection of FFT feedback and supporting training on the Meridian reporting system.

Progress

The overall response rate for Inpatients in January 2019 was 25.3%, this compares to 13% in December 2018 and 19.2% in November 2018. The reason for the reduction in response rate in December 2018 related a process issue related to the collection and transit of FFT feedback cards to our external provider at one hospital site. The issue has been identified and a robust process put in place to ensure consistent management.

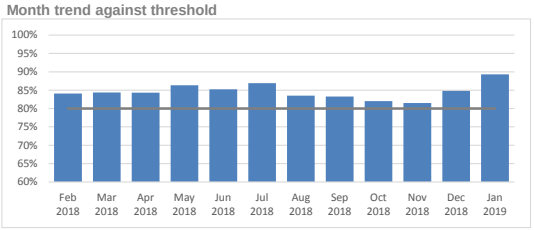
For our Emergency Departments the response rates have fallen slightly in January 2019 to 15.2%, this compares to 17.8% in December and 17% in November 2018.The majority of the Emergency Department feedback is via a text messages service which is more suitable for this patient cohort.

Nursing Workforce – Plan v Actual Compliance for RN

MFT

Actual	89.3%	Latest Period	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	NA	✓
	86.2%	91.1%	91.6%	90.5%		89.8%

As part of Safer Staffing Guidance the Trust monitors wards compliance with meeting their planned staffing levels during the day and night. This KPI provides the overall % compliance across all wards within the Trust with meeting the planned staffing levels. The actual staffing includes both substantive and temporary staff usage.

Progress

At the end of January 2019 there were 16 (14%) inpatient wards across the Group that had a registered nurse vacancy factor above 25%. The nurse fill rate has continued to improve since August when the rate was 83.3%.

Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels to meet the acuity and dependency of the patient group. Daily senior nurse staffing huddles are in place across the Hospitals

Actions

Where shortfalls in nurse staffing levels occur and this cannot be resolved, staff are redeployed from other areas following a risk assessment and professional judgement based on the acuity and dependency of patients in each area. Nursing assistant levels are increased in some areas to support such a shortfall and provide care and enhanced supervision for less acute but dependant patients. These processes are reviewed by the Directors of Nursing for each Hospital/MCS on a weekly basis.

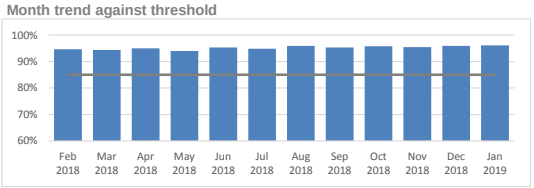
Acuity and dependency data is captured through the Allocate SafeCare system which supports senior nurses to review daily staffing levels and deploy staff safely.

Food and Nutrition

MFT

Actual	95.4%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✗	✗
97.7%	94.0%	93.7%	96.4%	95.1%	67.6%	84.6%

The KPI shows the % of the total responses to food & nutrition questions within the Quality Care Round that indicate a positive experience.

Progress

Improvement work continues at both Ward and Trust-wide level across all aspects of food and nutrition. Patient Dining Forums are established for ORC and WTWA. The Trust Improvement Programme 'Good to Great' is now led by the Head of Nursing (Quality and Patient Expereince) the Improvement Programme has been rolled out to WTWA, led by the Deputy Director of Nursing.

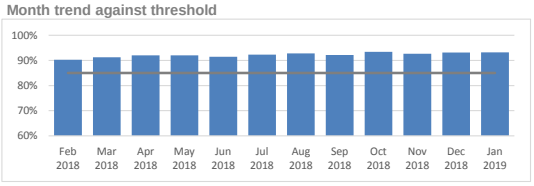
WTWA is progressing the recruitment of an additional Facilities Matron to expand the existing Facilities Matron team to support the delivery of quality improvement relating to Food and Nutrition.

Pain Management

MFT

Actual	92.5%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
96.0%	87.3%	87.7%	95.1%	97.2%	86.9%	93.1%

The KPI shows the % of the total responses to pain management questions within the Quality Care Round that indicate a positive experience.

Progress

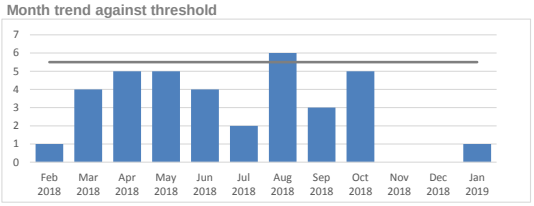
Work continues across the Trust to drive improvements in pain assessment and management.
The oversight for this work is now provided by the Deputy Director of Nursing, CSS who continues to lead work to establish a future work programme. Performance against this KPI is monitored through the Trust Harm Free Care structure.

Clostridium Difficile – Lapse of Care

MFT

Actual	31	Year To Date	**Accountability**	C.Lenney
Threshold	88	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✓	✓	✓	✓	✗
2	10	0	1	0	0	18

Each Clostridium difficile infection (CDI) incident is investigated to determine whether the case was linked with a lapse in the quality of care provided to patient. The maximum threshold for the Group is 105 lapses in care. The contractual sanction applied to each CDI case in excess of the target is £10,000. The KPI shows the number of CDI incidents that were linked to a lapse in the quality of care provided to a patient.

Progress

As of January 31st 2019. a total of 173 CDI cases have been reported for the 2018/2019 reporting year for MFT: 98 (56.6%) of which were trust-attributable, against a trajectory of 85. Following the monthly external case reviews, there has been a total of 31 Lapses in Care identified: Wythenshawe Hospital reported a total of 39 trust-attributable cases against a trajectory of 36 with 17 lapses in care. Oxford Road Campus/Trafford reported a total of 59 trust-attributable cases against a trajectory of 49 , with 14 lapses in care.

Actions

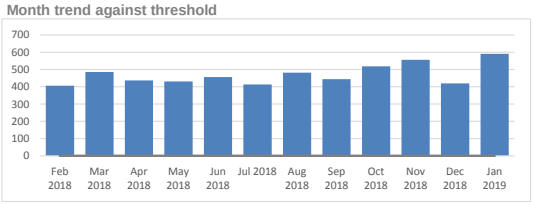
In response to increased incidents across the Trust, investigations continue to be undertaken by the IPC/TV team with a focus on antimicrobial stewardship, IPC practice in the clinical area and enhanced environmental cleaning in high incidence and high risk areas.

PALS – Concerns

MFT

Actual	4750	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
221	1353	468	386	282	144	1521

The number of PALS enquires received by the Trust where a concern was raised.

Key Issues

A total of 591 PALS concerns were received by MFT during January 2019. This compares to 420 PALS concerns received in December 2018 and 556 PALS concerns received in November 2018. This is within the limits of normal seasonal variation and is monitored closely.

The Hospital / MCS level performance against this indicator for year to date is detailed in the Hospital/ MCS Level Compliance Chart.

Actions

PALS concerns are formally monitored alongside complaints at weekly meetings within each Hospital / MCS.

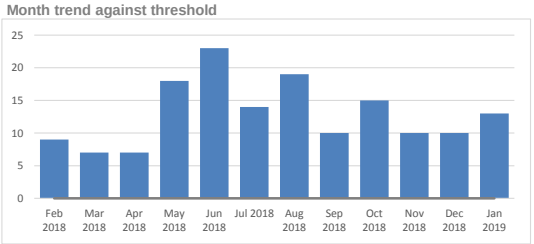
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management of cases over 5 days in place.

All Attributable Bacteraemia

MFT

Actual	139	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
16	75	11	7	0	0	30

MRSA and E.coli. There is a zero tolerance approach to MRSA bacteraemia.
For healthcare associated Gram-negative blood stream infections (GNBSIS), trusts are required to achieve a 50% reduction in healthcare associated GNBSIs by March 2021, with a focus on a 10% or greater reduction of E.coli in 2017/18 (based on number of incidents for 2016/2017). There are currently no sanctions applied to this objective.

Progress

From April to the end of January 2019, Wythenshawe Hospital have had 5 attributable MRSA bacteraemias and 25 attributable E. coli bacteraemias. Oxford Road Campus and Trafford Hospital have had 4 attributable MRSA bacteraemias and 100 attributable E. coli bacteraemias during the same period.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	×	No Threshold
	6	2	3	0

Headline Narrative

• Diagnostic standard - January 2019 delivery of 2.35% which is better than the national picture of 3.3% (December), but above internal trajectories. Ongoing demand pressures, for MRI scan coupled with workforce challenges in CSS and Adult Endoscopy have continued and previoiusly preported as a risk to recovery in January and into Q4.

• A&E 4 hours - In January MFT delivered a performance of 81.93%, with MFT ranked 2nd in GM. Trust focus on WTBS breaches at WTWA and Minors breaches at MRI continues. A number of plans are in place to ensure patient safety with strong performance for ambulance handover and no 12 hour trolley waits. Working with system partners relating to additional winter funding for adult social care, reductions in long length of stay patients and Joint working with GMMH, has resulted in a 23% reduction in Mental health breaches at MRI compared to the same period in 2017.

• RTT - MFT reported performance of 87.8% in January reflecting tactical actions taken for closed pathways. The Trust has seen an increase in the RTT waiting list, the national focus for 2018/19 is to maintain the waiting list size in March 19 compared to the previous year. The Trust is taking additional action in Q4, working with Commissioners on securing additional activity and demand management.

• +52 week Waits - In June 2018, the Trust had 292 over +52 week breaches. As of the end of January, there remains a total of 15 relating to DIEP procedures which is inline with the trajectory. A taskforce and PMO remains in place to manage the programme of work related to RTT and waiting times. On the Oxford Road Campus, discussions are taking place regarding an upgrade to PAS.

• Cancer 62 Day - Performance against the cancer standard is challenged in the MRI Hospital and SMH, with strong performance at WTWA. The Trust reported 80.52% against the 85% standard for Q3, with the greatest pressures in Urology and GI. A task force with MRI, CSS and the corporate performance team has been established to focus on improving timeliness of pathways, with MRI and CSS taking action to improve capacity. Furthermore, an exceptional meeting of the Trust Cancer Committee took place in January to bring clinical teams together to review the cancer pathways and best practice. NB. national changes to the reallocation of treatment and breaches is likely to impact on provider performance from Q3, despite no real change to pathways, and is a risk to MFT.

• Cancelled operations >28 days - There were 5 reportable breaches in January.

•The Board Assurance includes data aligned to Managed Clinical Sites, and whilst some sites will note a shift in performance, there has been no change to final submissions for the Trust.

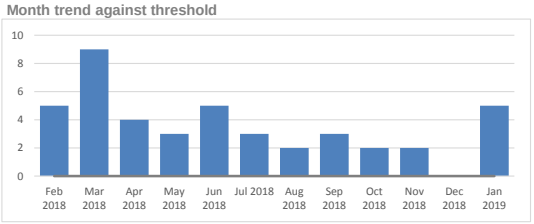
Operational Excellence - Core Priorities

Cancelled operations - rescheduled <= 28 days

MFT

Actual	29	Year To Date	**Accountability**	J.Bridgewater
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	×	✓	✓	✓	✓	×
0	19	0	0	0	0	10

Patients who have operations cancelled on or after the day of admission (for non clinical reasons) must be offered a binding date for their surgery to take place within 28 days.

Key Issues

Risk of non elective patient outliers in elective bed capacity.
System response to stranded patients > 7 and >21 days.
Urgent and emergency care pressures
Complex patients requiring specialist skills and beds

Actions

Cancelled operations are escalated and overseen through Hospital / MCS performance meetings, including risks to the 28 day standard.
Capacity and Demand plans and winter plans are in place to support Trust bed requirements which is a factor in cancellations.

Progress

•In January there were four 28 day breaches on the Oxford Road Site. The breaches occured in x2 Oral Surgery, x1 ENT and x1 Urology. The four patients went on to have their surgery carried out during January. Wythenshawe had one breach in Orthopaedics. The patient was treated on the 28th January 2019.
• MFT continues to perform strongly against this target, within the top three acute Trusts in GM.
• Nationally cancelled operations reschedule within 28 days performance remains significantly over target, reporting 8.3% in Q3 18/19.

> Board Assurance

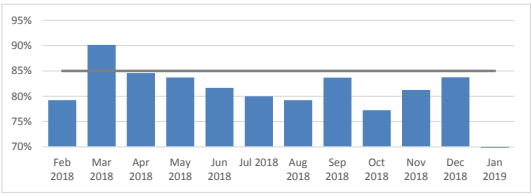
January 2019

Cancer 62 Days RTT

MFT

Actual	80.5%	Quarterly	**Accountability**	J.Bridgewater
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✗	NA	NA	✓
NA	71.3%	100.0%	80.4%	NA	NA	85.5%

The percentage of patients receiving first treatment for cancer following an urgent GP referral for suspected cancer that began treatment within 62 days of referral.

Key Issues

• The Trust continues to experience a significant increase in the demand for cancer services in excess of the national and regional profile, circa 20%.
• Capacity is affected in services where there are known national workforce shortages particularly radiology.

Actions

• Oversight and Monitoring by Hospital Cancer Boards.
• Assurance and challenge through AOF
• Senior Corporate monitoring and escalation of delays in patient pathway on cancer PTL
• Task force established with MRI, CSS and Corporate Performance team to support the review of cancer pathways at MRI.

Key Hospital/MCS Actions:

• Speciality level recruitment of workforce to match demand.
• Pathway developments i.e. Lung, LGI
• SMH increasing 2ww and diagnostic capacity
• CSS increasing diagnostic scan and reporting capacity
• An exceptional meeting of the MFT Cancer Committee was held in January to bring clinical teams together to discuss the most at risk pathways and required actions, which are being taken forward in the remainder of Q4 to support recovery.
• Breach allocation for each Tumour site to meet the standard and weekly reporting against this is taking place in Q4.

Progress

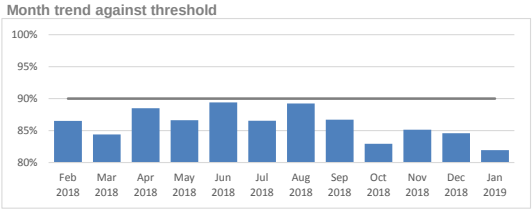
•The Trust is underperforming against the 62 day standard, although this has remained stable despite significant increase in demand.
• Q3 performance was 80.52%.
• The new national reallocation rules are a risk for all providers from Q3 when the changes will come into effect.
• Strong performance across some hospitals and WTWA continue to deliver the cancer standards.
• There is an improving trend for radiology reporting turnaround times for CT and MRI although performance was challenged in December
• The GM region is also experiencing increased pressure with demand growth, which is impacting on performance across a number of providers and underperformance of the 62 day standard.
• National performance against the standard: Q1 80.9%, Q2 78.6%.

A&E - 4 Hours Arrival to Departure

MFT

Actual	84.20%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.00%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	◇	✓	✓	✓	✗
NA	77.6%	88.5%	96.6%	99.9%	100.0%	84.5%

The total time spent in A&E - measured from the time the patient arrives in A&E to the time the patient leaves the A&E Department (by admission to hospital, transfer to another organisation or discharge). With a target that 95% of all patients wait no more than four hours in accident and emergency from arrival to admission, transfer or discharge.

Key Issues

• Acuity of patients with a high proportion of patients classified as Majors.
• Mutual aid to other GM providers is a risk of increased pressure on A&E and out of area admissions.
• Greatest challenges by Hospital include: Wythenshawe workforce deficits, MRI capacity and flow.
• Stranded patient data suggests there is a further opportunity to reduce long length of stay and improve flow, requiring support from system partners.
• Community capacity as alternative to A&E, Primary care capacity to facilitate increased streaming.
• Reduction/changes in community/care home capacity across GM.
• Age profile of presentations to Wythenshawe weighted with older, frail patients.

Actions

▪ Weekly Urgent Care Assurance meeting, chaired by Group COO/Director Performance.
▪ Hospitals have a number of plans in place that are being progressed to support resilience including:
  - 2019/20 Capacity Plans
  - Transformation plans and patient flow improvement boards
  - Winter plans in place.
▪ Adult Social and Community Care funding for winter to deliver additionality within the system and focus on reducing stranded patients.
▪ Working with system partners and the LCO to reduce long length of stay and improve discharge, reduction targets have been set. Additional work taking place in Q4 including: a pilot on wards AM1 and AM2 to improve discharge on these wards, and the Manchester ward, furthermore establishing a Integrated Discharge Team at MRI.
▪ Joint working with GMHH, task force established, working to improve ambulatory pathways and timely assessment of patients.
▪ Capital upgrade to Wythenshawe, MRI, and PED.
▪ Working with system partners to seek external expertise and assurance in relation to: long length of stay patients and corridor care.
▪ Escalated internal oversight arrangements are in place for Q4 with twice weekly meetings between the Group COO and Hospital Chief Executives. in addition, a weekly trajectory and management against this is in place to deliver an improvement in performance by the end of March.

Progress

• MFT reported 81.93% in January.
• Hospitals have agreed Q4 breach tolerance and supporting actions for February/March to secure step improvement in Q4.
• MFT GM ranking improved across Q3, and in January has consistently been 2nd or 3rd in the region.
• GM Performance for January 82%, National 84.4%.

> Board Assurance

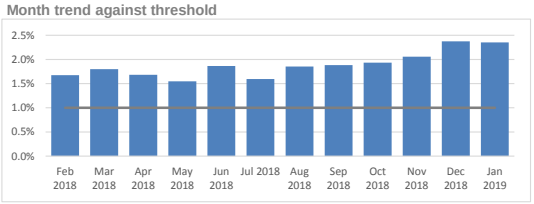
January 2019

Diagnostic Performance

MFT

Actual	2.4%	Latest Period	**Accountability**	J.Bridgewater
Threshold	1.0%	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	✗	◇	◇	NA	NA	✓
1.0%	9.8%	5.7%	13.0%	NA	NA	0.3%

NB - the % at RMCH and SMH is high due to the small waiting list in this area, the volume of breaches in these areas are marginal

The number of patients waiting over 6 weeks for a range of 15 key diagnostic tests.

Key Issues

- Demand for Diagnostic tests continues to increase in line with urgent and elective care pressures.
- Capacity constraints within adult Endoscopy and paediatric MRI.
- Ability to secure ad hoc sessions and workforce to increase capacity.

Actions

- Recovery trajectory in place for the key under performing tests with monitoring through the Trust AOF process.
- Paediatric MRI - recruitment of additional paediatric anaesthetists has been undertaken, and additional capacity secured.
- Implementation of the business case for the 3rd MRI scanner.
- Additional recurrent radiology sessions.
- Intensive actions being undertaken in adult endoscopy by MRI Director of Operations and include:
  - Review of scheduling, utilisation of clinics, securing additional capacity through the private sector.
  - Exploring options to transfer patients to community endoscopy following clinical risk assessment.
- Monthly forecasting in place, risks escalated to Hospital Directors.

Progress

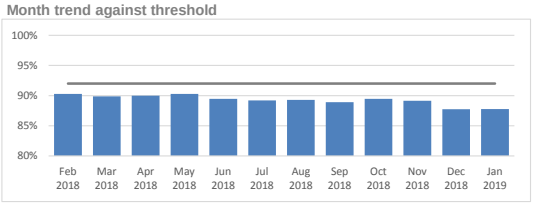
- Further step change improvement required to achieve the 1% standard on the Oxford Road Campus.
- Significant improvement in paediatric Endoscopy means this is no longer a risk.
- Despite improvements up until July, workforce pressures from August have continued to impact on the Trusts ability to sustain and deliver further improvement to meet the 1% target
- Revised trajectory for adult endoscopy and CSS.

RTT - 18 Weeks (Incomplete Pathways)

MFT

Actual	87.8%	Latest Period	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	✗	✗	✓	✓	✗
92.2%	90.3%	85.1%	83.1%	92.9%	92.9%	86.2%

The percentage of patients whose consultant-led treatment has begun within 18 weeks from the point of a GP referral. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.

Key Issues

- Demand for Trust services continues to grow, particularly for specialist services and cancer.
- WTWA DIEP service - A trajectory to reduce breaches by 50% by March 19 is in place.
- Oxford Road Campus - A review of long waits, identified additional 52+ week breaches between June - September, trajectory to eradicate to zero achieved.

Actions

- RTT Task force focusing on long wait patients, chaired by Deputy COO/ Chief Informatics Officer, in place.
- Action plans in place which includes clinical review and focus on patient safety, and offering patients surgery dates.
- RTT PMO office established from September.
- Continued timely validation of PAS/waiting lists by Hospital sites, and data quality audits on-going.
- Additional resource to support validation and accuracy of data.
- Delivery of Hospital/MCS transformation and capacity plans.
- MFT Patient Access Policy in place.
- Participation in the NHSI Masterclass for RTT
- Participation in NHSI Capacity and Demand modelling training.
- Working with Commissioners in relation to demand management, particularly for specialist hospitals, to support stability of the waiting list.
- Supported by Commissioners additional capacity in the private sector has been secured in Q4 to treat patients and reduce the overall waiting list size

Progress

- The Trust has successfully delivered its commitment to eliminate the non-RTT breaches 52+ weeks at the Oxford Road Campus from September onwards.
- A significant improvement has been made from 293 +52 week waits in June to 15 in January. The remaining breaches relate to DIEP procedures, which are better than trajectory, with the Trust required to have no more than 15 by March 19.
- Trust RTT performance in January of 87.8% reflects the National profile of 87.3% (latest November)
- Trust waiting list has increased by 6.97% since March 18.

> Board Assurance

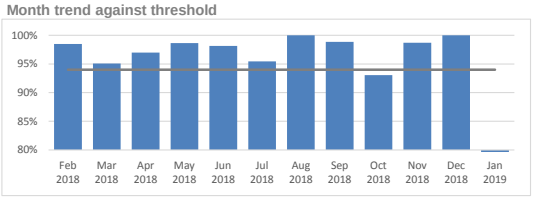
January 2019

Cancer 31 Days Sub Surgical Treatment

MFT

Actual	97.1%	Quarterly	**Accountability**	J.Bridgewater
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	✗	NA	NA	✓
NA	96.0%	NA	88.2%	NA	NA	98.2%

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was surgery.

Key Issues

The Trust met the target for Q1.

Actions

Actions taken as per the 62 day standard.

Progress

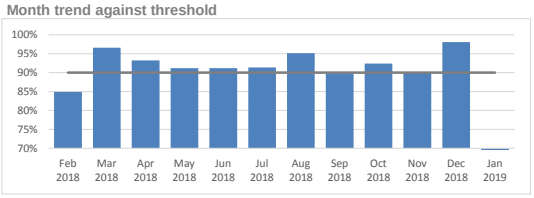
The Trust achieved the target in Q3, performance is 97.1%

Cancer 62 Days Screening

MFT

Actual	92.9%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✓	NA	NA	✓
NA	60.0%	NA	100.0%	NA	NA	96.3%

The percentage of patients receiving first definitive treatment for cancer following referral from an NHS cancer screening service that began treatment within 62 days of that referral.

Key Issues

The Trust has delivered performance against this standard.

Actions

Actions to improve and refine current cancer pathways included in Divisional cancer plans submitted to Cancer Board.

Progress

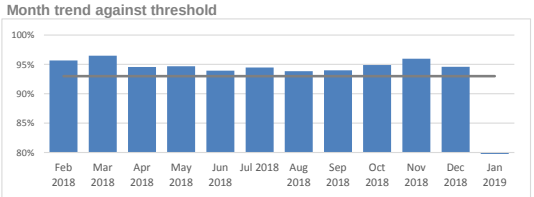
The Trust achieved this target in Q3, performance is 92.9%

Cancer Urgent 2 Week Wait Referrals

MFT

Actual	95.2%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✗	NA	NA	✓
NA	93.6%	100.0%	88.9%	NA	NA	96.7%

The percentage of patients urgently referred for suspected cancer by their GP that were seen by a specialist within 14 days of referral.

Key Issues

Increased demand in 2 week wait referrals continues to place pressure on MFT cancer services. Q3 18/19 has seen an additional 1171 referrals (19%) increase compared to Q2 17/18.

Actions

Collaborative actions taken with speciality teams to strengthen performance and increase the volume of patients seen within 7 days, within the workforce available.
SMH have reviewed the Gynaecology pathway and have an action plan in place but currently under performing.
GM have recognised the increase in demand is significant across the region and are reviewing the demand profile.
Q4 on ORC is at risk - WTWA currently ok.

Progress

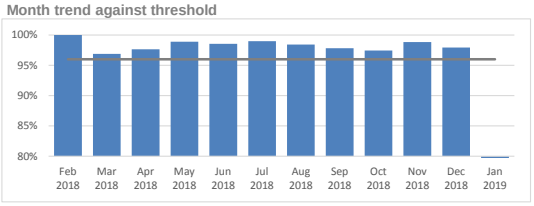
Trust continues to deliver the standard

Cancer 31 Days First Treatment

MFT

Actual	98.0%	Quarterly	**Accountability**	J.Bridgewater
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	✓	✓	NA	NA	✓
NA	95.6%	100.0%	96.7%	NA	NA	99.0%

The percentage of patients receiving their first definitive treatment for cancer that began that treatment within 31 days.

Key Issues

The Trust has achieved this standard. MRI had 2 breaches in December.

Actions

Actions taken as per the 62 day standard.

Progress

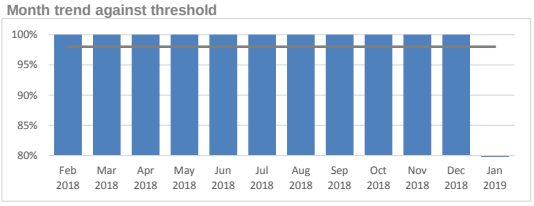
The Trust continues to achieve this standard

Cancer 31 Days Sub Chemo Treatment

MFT

Actual	100.0%	Quarterly	**Accountability**	J.Bridgewater
Threshold	98.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	✓	NA	NA	✓
NA	100.0%	NA	100.0%	NA	NA	100.0%

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was an anti-cancer drug regimen.

Progress

The Trust continued to achieve the standard.

Actions

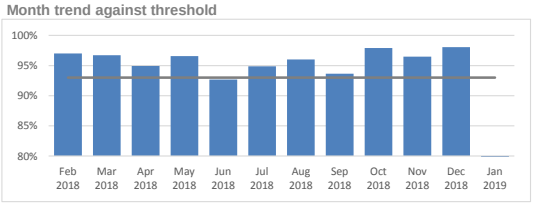
Actions taken as per the 62 day standard.

Cancer 2 Week Wait - Breast

MFT

Actual	97.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	NA	NA	NA	NA	NA	✓
NA	NA	NA	NA	NA	NA	97.4%

Any patient referred with breast symptoms would be seen within 2 weeks, whether cancer was suspected or not.

Key Issues

Specialist cancer services are provided by Wythenshawe Hospital. The Hospital continues to deliver strong performance against this standard.

Progress

The Trust achieved 98.1% in December, against National 88.1% (latest data)

Workforce and Leadership

M.Johnson

Core Priorities	✓	◇	✕	No Threshold
	5	0	6	3

Headline Narrative

The Trust achieved its flu vaccination target of 75% of Flu vaccinations with 13,700 vaccinations administered in this year's programme. The programme continues to run until the end of February and the Employee Health and Wellbeing team continue to encourage all MFT staff to have the vaccination.

HR are currently developing a new Leadership and Improvement academy. Quality Improvement Foundation Level training has been developed ready for launch from 1st April. The curriculum for Champion and Practitioner level has been developed with AQuA ready for launch from 1st April.

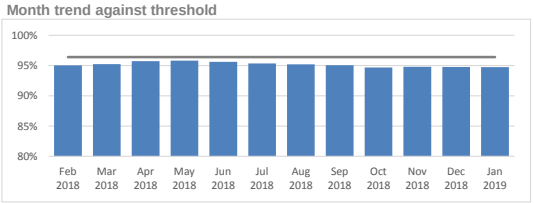
Workforce and Leadership - Core Priorities

Attendance

MFT

Actual	94.7%	Latest Period	**Accountability**	M.Johnson
Threshold	96.4%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✕	✕	✕	✓	✕
95.8%	94.5%	95.2%	94.6%	94.8%	96.5%	93.7%

This monitors staff attendance as a rate by comparing the total number of attendance days compared to the total number of available days in a single month.

Key Issues

The Groups attendance rate for December has decreased to 94.7% compared to the previous months figure (94.8%).

The attendance rate was slightly higher at the same point last year (January 2018) at 94.9%.

Meanwhile the latest figures released by NHS Digital show that for October 2018 the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.00% (these figures include all provider organisations and commissioners). MFTs performance for the same period was 5.2%. Performance in the North West is significantly below that of the South East sector.

Actions

Work is underway to ensure Health and Wellbeing initiatives are focussed in areas where the biggest improvements can be made. The HWB programme for 2019/20 is currently in development

In the Manchester Royal Infirmary a MRI Workforce Performance (KPI) group was established in January 2019 to understand the information that is available to managers within the MRI to monitor and improve key performance indicators such as sickness absence. As part of the actions from the MRI Workforce Performance (KPI) group the next meeting in February will also have sessions for managers within the MRI focussing on the Sickness Policy.

In Wythenshawe, Trafford, Withington and Altrincham (WTWA) sites there has been an emphasis on greater benefits realisation through Absence Manager system and the associated benefits of increased data capture and accuracy. Monitoring of managers compliance in relation to call back and return to work discussions is measured through the Absence Manager dashboards at Divisional Performance Review meetings.

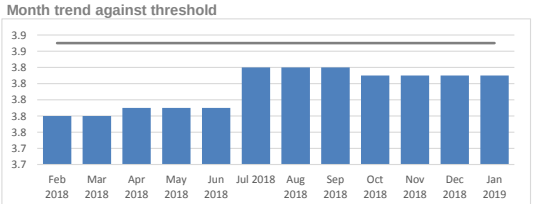
Actions plans have been put in place and are monitored via the Accountability Oversight Framework.

Engagement Score (quarterly)

MFT

Actual	3.83	Latest Period	**Accountability**	M.Johnson
Threshold	3.87	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✕	✓	✕	✓	✕
3.79	3.77	3.85	3.88	3.86	3.99	3.83

This indicator measures the Staff Engagement score taken from the annual Staff Survey or quarterly Pulse Check. This score is made up of indicators for improvements in levels of motivation, involvement and the willingness to recommend the NHS as a place to work and be treated.

Key Issues

The initial 2018 Staff Survey results have been published.There have been a number of significant national changes to the reporting of the staff survey results for 2018, including the replacement of the previous 5 point scale with a 10 point scale. Our Group Staff engagement score is 7.1. This compares with a recalibrated staff engagement score for 2017 of 6.97 (rounded to 7.0 in national reporting). The new reporting scores will be shown on this report from February 2019's report onwards and previous scores will be recalibrated to the 10 point scale.

Actions

The 2018 Staff Survey results will provide staff engagement scores at Group and Hospital/MCS/Corporate level. These are being disseminated across the Group. All scores are being reported using the new 10-point scale.The Quarter 4 Pulse Survey will launch in February. The lessons learnt from the 2018 Staff Survey have been reviewed to inform our approach to this year's survey, and to how we measure staff engagement through Pulse Checks. These are currently being implemented.

> Board Assurance

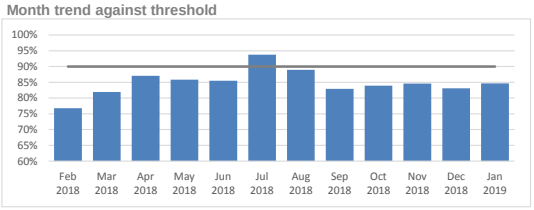
January 2019

Appraisal- medical

MFT

Actual	84.6%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	✗	✗	◇	✗	✗	◇
87.1%	80.2%	81.4%	89.0%	82.4%	78.1%	88.8%

These figures are based upon compliance for the previous 12 months for Medical & Dental staff.

Key Issues

Medical Appraisal compliance increased by 1.5% in December and is now 84.6% - 5.4% below target. No Hospitals are achieving target compliance.

Actions

All Hospitals continue to deliver plans that were presented to the HR Scrutiny committee in June. Members of the Medical Director and Group Executive Director of HR & OD teams have put in place a number of actions to ensure that there are no anomalies in the reporting process. The Group Director of HR and OD has written to all Hospital CEOs requesting that they urgently review the appraisal planning process to ensure that target compliance is achieved in the shortest possible timescale. These plans were discussed at the January Risk Management Committee.

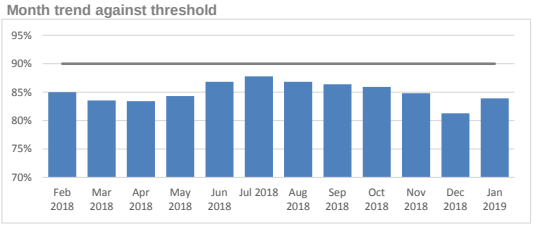
Discussions have taken place between the Professional Standards Manager and WTWA HR Business Partner to clarify the metrics used for the Medical Appraisal Accountability Oversight Framework (AOF) and ensure these reflect the accurate appraisal position; this will be simplified with the roll-out of the new SARD appraisal system as all clinicians will be on one system and divisions will be able to access and interrogate the source data directly.

Appraisal- non-medical

MFT

Actual	83.9%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	◇	◇	✓	✓	✓	◇
83.9%	88.3%	86.7%	90.1%	91.0%	90.3%	86.2%

These figures are based upon compliance for the previous 12 months, new starters are now included in these figures and will be given an appraisal date with a 3 month compliance end date, in line with the appraisal policy statement: 'new starters should have an initial appraisal meeting within three months of commencement in post'. These figures do not include Medical Staff.

Key Issues

Non Medical Appraisal compliance for the Group in December increased by 2.7% to 83.9%. 3 Hospitals are achieving target compliance compared to none the previous month.

Actions

All Hospitals are currently working to plans that were presented to the HR Scrutiny Committee and have provided assurance that they are still on target to achieve 90% or above compliance by March 2019

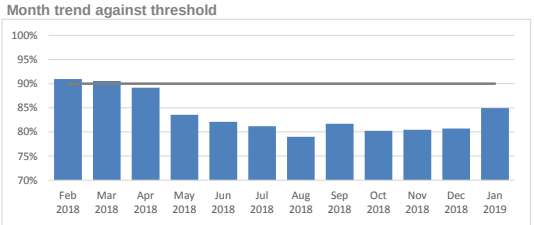
Reports continue to be forwarded to Hospital HRDs to support their management teams in planning appraisal activity to redress the negative trend. The new Appraisal policy is on target to be implemented from 1st April 2019. The Group Director of HR and OD has written to all Hospital CEOs requesting that they urgently review the appraisal planning process to ensure that target compliance is achieved in the shortest possible timescale. These plans were discussed at the January Risk Management Committee.

Trust Mandatory Training - Clinical

MFT

Actual	85.0%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	◇	✗	✓	✗	✗	✗
82.8%	88.6%	81.8%	90.7%	83.8%	81.0%	80.0%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken clinical mandatory training within the previous 12 months.

Key Issues

Compliance increased by 0.1% in January. Only 1 Hospital is achieving target compliance.

Actions

The Hospital HR Directors (HRDs) are ensuring that their management teams are prioritising Clinical Mandatory training compliance improvements as a matter of urgency. The alignment of clinical mandatory training across the Group is being progressed by a task and finish group involving key professional leads. This will be completed by the end of March 2019. The new programme will be mapped to individual staff's learning accounts which should alleviate issues of incorrectly self-enrolling on the wrong programmes. Additionally staff will receive e mail reminders from 3 months before the expiry date of a competence; this has been very effective in the roll out of Core Level 1 mandatory training. A paper was presented to the Workforce Education Committee and Professional Education Forum in January and actions arising from those meetings are being incorporated into an extensive communication plan that will be implemented from the last week in February.

> Board Assurance

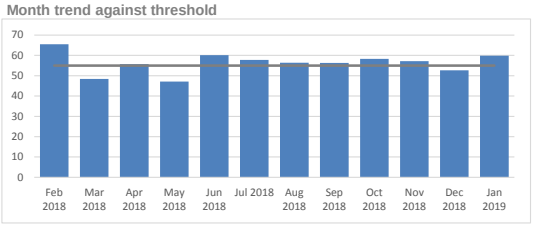
January 2019

Time to fill vacancy

MFT

Actual	59.9	Latest Period	**Accountability**	M.Johnson
Threshold	55.0	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✓	✗	✗	✗
57.3	72.4	71.5	50.4	62.0	76.5	58.3

This indicator measures the average time it takes, in days, to fill a vacancy. It measures the time taken from the advertising date (on the TRAC Recruitment system), up to the day of unconditional offer. The graph shows an in month rate.

Key Issues

Group wide, the Time to Fill figure (which doesn't include Staff Nurses) has increased from 52.7 days and now stands at 59.9 days for January.

Actions

The Trust 'Time to Hire' for January 2019 without Band 5 Nursing starts is 59.9 working days on average which is an increase of 7 working days from Decembers figures and is 4.9 working days over the Trust target. The number of candidates submitting an application in January 2019 is 7557 (up 23.5% on the December 2018 figure) and 427 jobs were advertised. We had 634 new starters (395 external 239 internal) a significant increase of 51.3% from a figure 419 in December 2018 – the booking of so many start dates during the month of January 2019 has had a significant impact on the Time To Fill increase.

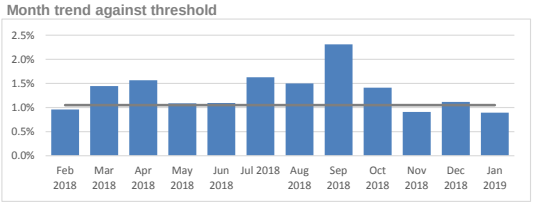
In parallel to ongoing activity processing, a deep dive analysis of recruitment processes is being undertaken to understand where any delays may be occurring so this can be rectified.

B5 Nursing and Midwifery Turnover (in month)

MFT

Actual	0.89%	Latest Period	**Accountability**	M.Johnson
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✓	✓	✓	✓	NA	✗
1.11%	0.79%	0.43%	0.71%	0.00%	NA	1.50%

This indicator measures and monitors the turnover of Band 5 Qualified Nursing & Midwifery staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes Fixed Term Contract staff). The graph show the rate in a single month.

Key Issues

The turnover for the month is 0.89% against a monthly target of 1.05%. This is an decrease in turnover from the previous month at which the turnover was 1.12%.

The turnover rate was much higher at the same point last year (January 2018) at 1.21%.

Actions

A retention workshop was held with Directors of Nursing and HR in January 2019 focusing on Nursing and Midwifery Retention.

Nursing and Midwifery Retention Strategies have been developed by each Hospital/MCS and are monitored by the Directors of Nursing.

The strategies focus on the following work streams:-

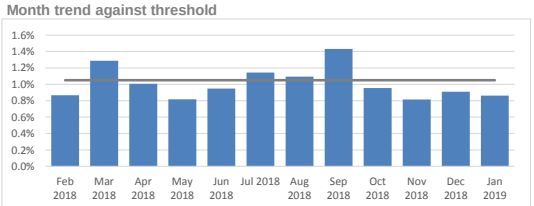
- Divisional work streams focusing on wellbeing/staff focus groups/take a break
- Nursing and Midwifery extended induction for new starters
- Roll-out of 12 hour shifts for staff who wish to condense their hours over a shorter working week
- Identifying new roles within the unregistered workforce to support careers/skills escalator
- Band 5 rotation programmes have been introduced in RMCH, MRI and WTWA

Turnover (in month)

MFT

Actual	0.86%	Latest Period	**Accountability**	M.Johnson
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✓	✓	✓	✓	✗	✓
1.17%	0.70%	0.76%	0.69%	0.47%	1.45%	0.83%

This indicator measures and monitors the turnover of staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes the naturally rotating Foundation Year 1 and Year 2 junior medical staff and the Fixed Term Contract staff). The graphs shows a single month rate.

Key Issues

The single month turnover position for the group has decreased and now stands at 0.86% compared to 0.90% for the previous month.

The turnover rate was higher at the same point last year (January 2018) at 0.96%.

Actions

The Hospitals continue to focus on staff turnover with regular staff engagement sessions, facilitating internal moves to prevent staff leaving the organisation.

The Exit Questionnaire process is currently being aligned across all the hospitals. Staff leaving the Trust at Wythenshawe will complete exit questionnaires on the electronic Workforce Information portal (eWIP). This will create an improved reporting function at Wythenshawe for leaver information on eWIP.

> Board Assurance

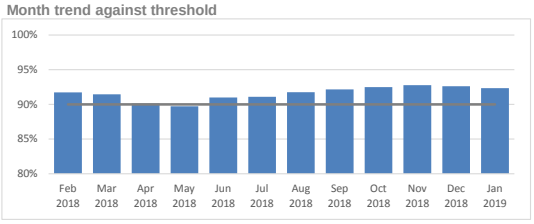
January 2019

Level 1 CSTF Mandatory Training

MFT

Actual	92.3%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✗	✗	✓
92.7%	91.5%	91.4%	96.0%	89.0%	87.8%	92.2%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken corporate mandatory training within the previous 12 months.

Key Issues

Performance in November for the Group has seen compliance decrease by 0.2% to 92.3%. Nearly all hospitals and Corporate Divisions are achieving target compliance

Actions

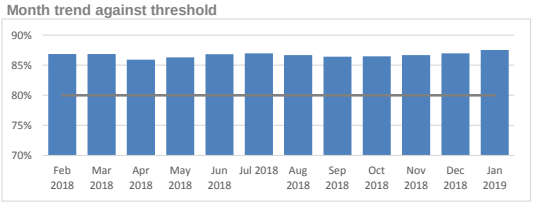
Detailed monthly reports are being shared with HRDs.

Nurse Retention

MFT

Actual	87.5%	Latest Period	**Accountability**	M.Johnson
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	NA	✓
82.9%	80.7%	86.2%	86.9%	89.1%	NA	85.4%

This indicator measures the Nursing & Midwifery staff retention rate. It measures, by %, the Nursing & Midwifery registered staff in post for the Trust 12 months ago who are still employed in the organisation to date.

Key Issues

Nursing and Midwifery retention stands at 87.5% which is a slight increase to the previous month at which the retention rate was 87.0%. This rate remains above the threshold of 80%.

Actions

The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 87.5%.

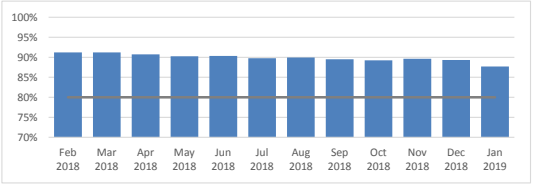
A retention workshop was held in January 2019 for senior nursing and HR colleagues to review and develop a retention action programme in support of retaining the nursing workforce.

BME Staff Retention

MFT

Actual	87.7%	Latest Period	**Accountability**	M.Johnson
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
86.7%	81.6%	87.8%	86.7%	87.2%	87.5%	83.6%

This indicator measures the Black minority & Ethnic (BME) staff retention rate. It measures, by %, the BME staff in post for the Trust 12 months ago who are still employed in the organisation to date. The retention rate information excludes the naturally rotating Foundation Year 1 and Foundation Year 2 junior medical staff. The rate is shown as a rolling 12 month position.

Key Issues

Black and Minority Ethnic staff are as likely to remain at the trust as White staff, at 87.7% retention compared to 87.75%. The Group is exceeding its retention threshold for this indicator, which is an 80% threshold. The retention rate remains consistent month on month at around 88/89%.

Action

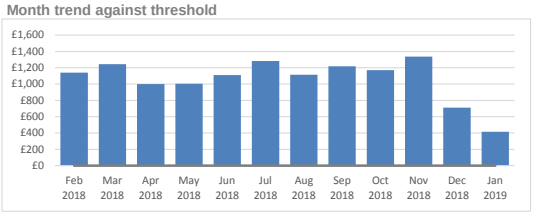
The Group continues to perform strongly on this indicator with a variation in Research and Innovation. Hospital Sites/MCSs and Functions are tracking this within their Accountability Oversight Framework and developing plans to address where negative gaps are being identified.

Medical Agency Spend

MFT

Actual	£414.1	Latest Period	**Accountability**	M.Johnson
Threshold	None	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
£29.9	£49.3	£30.7	£6.3	£76.4	£2.9	£207.0

The Medical and Dental Agency Spend figure represents the cost of supply/temporary M&D staff throughout the Trust. This may represent cover for long term absences either through vacancies, long term illnesses or for other specific staffing requirements. The value is in £000s and is the reported month cost.

Key Issues

For January 2019 the total value of Medical and Dental agency staffing was £414k.

Actions

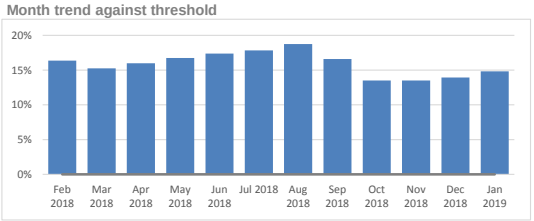
Each Hospital continues to review their agency spend by identifying exit plans for each long term agency worker, and where possible, transitioning these staff to bank or fixed term Trust posts. There are a number of work streams relating to Temporary Staffing currently progressing which include additional pay/bank rates harmonisation and the negotiation of agency commission rates to demonstrate a reduction. Weekly dashboards are being developed to enable the Management Teams to understand the spend, and therefore target areas for reduction.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

MFT

Actual	14.8%	Latest Period	**Accountability**	M.Johnson
Threshold	None	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
14.2%	17.6%	11.7%	7.3%	10.5%	NA	18.0%

The Qualified Nursing and Midwifery vacancy rate represents the total number of posts vacant within the Band 5 Nursing and Midwifery staff group, including Operating Department Practitioners.

Band 5 and 6 Midwifery vacancies are reported together as these posts are transitional posts for entry level (newly qualified) midwives who progress to band 6 on completion of preceptorship.

Key Issues

The majority of vacancies with Nursing and Midwifery are within the staff nurse (band 5) role. At the end of January 2019 there were 590.5 wte (14.8%) staff nurse/midwife/ODP (band 5) vacancies across the Trust Group. This is an increase from December 2018 when there was 554.5 wte vacancies.

Actions

There are 41 nurses and midwives due to start before the end of April 2019 with a further 214 nurses with conditional job offers and whose appointments are being processed through the Trust recruitment process. The trust continues to recruit nurses from overseas. There will be 20 international nurses starting in the Trust in February 2019 with a further 35 expected to start in March 2019.

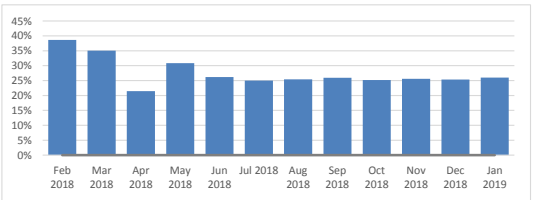
A Group Resourcing Plan has been developed including a schedule of recruitment events to support the recruitment strategies implemented across the Hospitals and MCS

% BME Appointments of Total Appointments

MFT

Actual	26.0%	Latest Period	**Accountability**	M.Johnson
Threshold	None	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
29.6%	35.3%	21.3%	18.0%	42.5%	31.3%	29.0%

This indicator measures the number of BME appointments as a percentage of all appointments. This is measured through the Trust's Recruitment system (TRAC). The graph shows an in month rate.

Key Issues

There has been a rise of 0.67% in BME recruitment to over a quarter at 26.04% from 25.37%. Manchester Local Care Organisation, Saint Marys Hospital and Research and Innovation most significantly appoint at percentages lower than the Group average though consistent with the size of the Greater Manchester black and minority ethnic population and Royal Manchester Eye Hospital, Manchester Royal Infirmary and Trafford Hospital above the group average.

Actions

The Group figure is higher than the Greater Manchester black and minority ethnic population of almost 17%, which over 80% of the trust's workforce is drawn from, but lower than the Manchester black and minority ethnic population of over 30%. Hospital Sites/MCSs and Functions are tracking this within their Accountability Oversight Framework and developing plans to address where negative gaps are being identified.

Finance

A.Roberts

Core Priorities	✓	◇	✕	No Threshold
	0	1	1	0

Headline Narrative

- Please see agenda item 5.2

Finance - Core Priorities

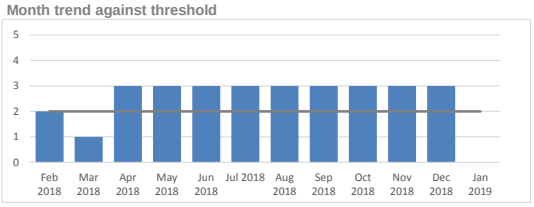
Regulatory Finance Rating

MFT

Actual 3 Latest Period **Accountability** A.Roberts

Threshold 3 (Lower value represents better performance) **Committee** TMB and Board Finance Scrutiny Committee

Month trend against threshold



The regulatory finance rating identifies the level of risk to the ongoing availability of key services. A rating of 4 indicates the most serious risk and 1 the least risk. This rating forms part of NHSI's single oversight framework, incorporating five metrics:

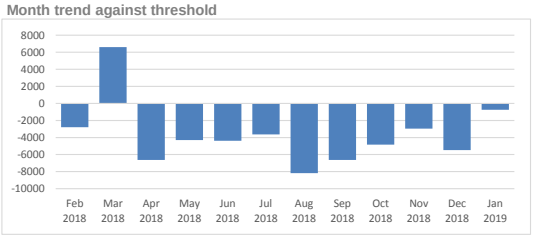
- Capital service capacity
- Liquidity
- Income and expenditure margin
- Distance from financial plan
- Agency spend

Operational Financial Performance

Actual -£47,786 Year To Date **Accountability** A.Roberts

Threshold **Committee** TMB and Board Finance Scrutiny Committee

Month trend against threshold



Comparing the financial actual expenditure against the agreed budget (£'000). A negative value represents an overspend. A positive value represents an underspend.

Please see the Chief Finance Officer's report for more detail.

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	◇	✕	✕	✕	✕

Strategy

Core Priorities	✓	◇	×	No Threshold
	1	2	0	0

Headline Narrative

The Trust is in the process of developing its Clinical Service Strategy. This will comprise an over-arching group service strategy and a series of individual clinical service strategies. The Clinical Service Strategy programme commenced in April 2018 and is expected to conclude in May 2019. The first version of the group service strategy has been approved by the Board and will be further iterated as the programme proceeds. Draft clinical service strategies are currently under development.
Annual plans are in place for all Hospitals / MCSs for 2018/19. The development of plans for 2019/20 has commenced.
All Hospitals / MCSs are making satisfactory progress towards the delivery of the strategic service development milestones in their Annual Plan.

Strategy - Core Priorities

Agreed 5-year strategy in place

MFT

◇ **Actual** Amber **Accountability** D.Banks
Threshold **Committee** Group Management Board

Each service should have a 5 year strategy setting out their vision and strategic aims and the key milestones towards achieving their vision. This should be approved by the Trust Service Strategy Committee.

Green indicates that a strategy has been completed and approved by the Trust Service Strategy Committee
Amber indicates that a strategy is being developed but has not yet been approved.
Red indicates that there has been no progress towards the development of a strategy.

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	◇	◇	◇	◇	◇

Agreed annual plan for 2018-19

MFT

✓ **Actual** Green **Accountability** D.Banks
Threshold **Committee** Group Management Board

Each service should have an annual plan setting out the actions that they are going to take in the coming year to deliver all local and national targets and actions towards achieving their vision and strategic aims. It will include a financial plan showing how this will be achieved within budget.

Green indicates that an annual plan has been completed and approved by the Group Management Board
Amber indicates that an annual plan has been developed but not approved.
Red indicates that there has been no progress towards the development of an annual plan

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓

Progress against delivery of service strategy milestones in annual plan

MFT

◇ **Actual** **Accountability** D.Banks
Threshold **Committee** Group Management Board

Progress against the strategic development plans set out in the annual plan is monitored on a quarterly basis.

Green – consistent delivery against all milestones
Amber – delivery largely on track i.e. small number of milestones not being met or delivery slightly behind plan
Red – delivery of milestones not on track i.e. majority of milestones not being met or significantly behind plan

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	◇	◇	◇	◇	◇

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Single Hospital Service Director
Paper prepared by:	Sophie McCormick, Assistant Director, Single Hospital Service
Date of paper:	11th March 2019
Subject:	Progress report on the Manchester Single Hospital Service
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Failure to deliver the post-merger integration programme and the NMGH acquisition will adversely impact the aspiration to develop a Single Hospital Service within the City of Manchester.
Recommendations:	The Board of Directors is asked to receive the report and note the progress made and on-going actions.
Contact:	Name: Peter Blythin Single Hospital Service Director Tel: 0161 701 8573

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

PROGRESS REPORT ON THE MANCHESTER SINGLE HOSPTIAL SERVICE

1. Introduction

1.1 The purpose of this paper is to provide an update to the Board of Directors on the Single Hospital Service (SHS) Programme.

1.2 The proposal to establish a Single Hospital Service in Manchester is a key element of the Manchester Locality Plan. The Programme is being delivered through two connected projects.

- **Project One**: the programme of integration activity following the creation of Manchester University NHS Foundation Trust (MFT) through a merger of two NHS Foundation Trusts on 1st October 2017.

- **Project Two**: the proposed acquisition and transfer of North Manchester General Hospital (NMGH) into MFT from Pennine Acute Hospital NHS Trust (PAHT).

2. Project One: Post-merger Integration

2.1 Overview

2.1.1 Integration activity is continuing across MFT with an increasing emphasis on the more complex programmes of work aimed at harmonising patient pathways. Group Executive Directors supervise integration activity within their portfolios and overall oversight of the integration programme is maintained by the Integration Steering Group (ISG), chaired by the SHS Director.

2.1.2 The Integration Management Office (IMO) continues to provide support and progress reporting to the ISG and the Operations and Transformation Oversight Group. It engages regularly with work stream leads to ensure timely and accurate reporting of issues into the relevant governance structures and to enable robust benefits management.

2.2 Post Transaction Integration Plan

2.2.1 To support robust integration planning for Year 2 post-merger and beyond, the Post Transaction Integration Plan (PTIP) has been updated to reflect the position at one year post merger. The PTIP is primarily a document for internal use by the organisation in the planning and management of integration activity. It provides an overview of what has been delivered during Year 1 post merger and sets out the high level plans for future integration activity over Year 2 post merger and beyond. It also provides an overview of the management and delivery arrangements, including the progress monitoring and risk management process, in addition to the approach taken to benefits management.

2.2.2 This will be the final iteration of the PTIP relating to the merger since work streams will increasingly continue to the deliver their integration benefits though business as usual processes overseen by the relevant Group Executive Director or Hospital/Managed Clinical Service Chief Executive.

2.3 Manchester Agreement Metrics

2.3.1 MFT is held to account by Manchester Health and Care Commissioners (MHCC) on the delivery of a series of measureable patient benefits outlined in the Manchester Investment Agreement. Formal reporting of the Manchester Investment Agreement patient benefits takes place on a quarterly basis and involves Greater Manchester Health and Social Care Partnership (GMH&SCP) in addition to MHCC. The latest return was made on 1st February 2019 and MFT reported compliance with the metrics that are currently monitored.

2.3.2 MFT colleagues are due to attend a meeting with MHCC and GMH&SCP to update on the delivery of the Manchester Agreement metrics in more detail. At this meeting clinicians, service managers and colleagues from the SHS and Transformation Teams will present updates on the improvements MFT has been able to realise as a result of the merger.

3. Project 2: Planned acquisition of NMGH

3.1 MFT continues to progress the proposed transaction to acquire NMGH from PAHT as part of an overall plan to dissolve PAHT and transfer the remaining hospital sites to Salford Royal NHS Foundation Trust (SRFT). MFT is working collaboratively with MHCC, PAHT, SRFT, NHS Improvement (NHS I) and colleagues at GMH&SCP to ensure the two transactions associated with the dissolution of PAHT are progressed as efficiently as possible. This includes engagement through the Transaction Board that has been established to maintain oversight of the process.

3.2 A strategic case relating to the proposed acquisition of NMGH is being developed in line with NHSI's regulatory framework and guidance governing transactions. The case focusses on the strategic rationale that will determine if MFT can proceed to the business case stage of the transaction. It is planned, subject to Board of Director approval, that the strategic case will be submitted for formal consideration by NHSI by the end of March 2019. SRFT is also in the process of developing a strategic case in relation to the remainder of PAHT and work is being undertaken to ensure that the two strategic cases align where necessary and appropriate.

3.3 Despite progress with the development of the strategic case there remain a number of significant challenges to address in relation to the acquisition of NMGH, including the condition of the NMGH estate and the financial investment that will be required to remediate this and support the safe transfer of NMGH to MFT. Group Executive Directors are attentive to these issues as part of the preparation of the strategic case.

3.4 In anticipation of the planned transaction, the SHS Team is providing regular briefings to the Council of Governors. The Team, along with Group Executive Directors and MHCC colleagues, is also continuing to engage with NMGH colleagues through a staff engagement programme. The most recent engagement event took place on 13th February 2019 and this was positively received by staff.

3.5 Updates on progress in delivering the SHS Programme as part of the wider Manchester Locality Plan were provided to the Manchester Health and Wellbeing Board on 23rd January 2019 and Manchester Health Scrutiny Committee on 5th February 2019.

4. Conclusions

4.1 The post-merger integration work to realise patient benefits and ensure that the new Trust is operating efficiently and effectively is progressing well. The PTIP has recently updated to reflect the position at one year post-merger and the ISG will continue to maintain oversight of the breadth of the integration programme.

4.2 MFT remains committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT. To enable this MFT is progressing the development of a strategic case and continues to engage with all key stakeholder, in particular, with GMH&SCP and NHS I in their roles to oversee the plan to dissolve PAHT.

5. Recommendation

5.1 The Board of Directors is asked to note the content of the report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

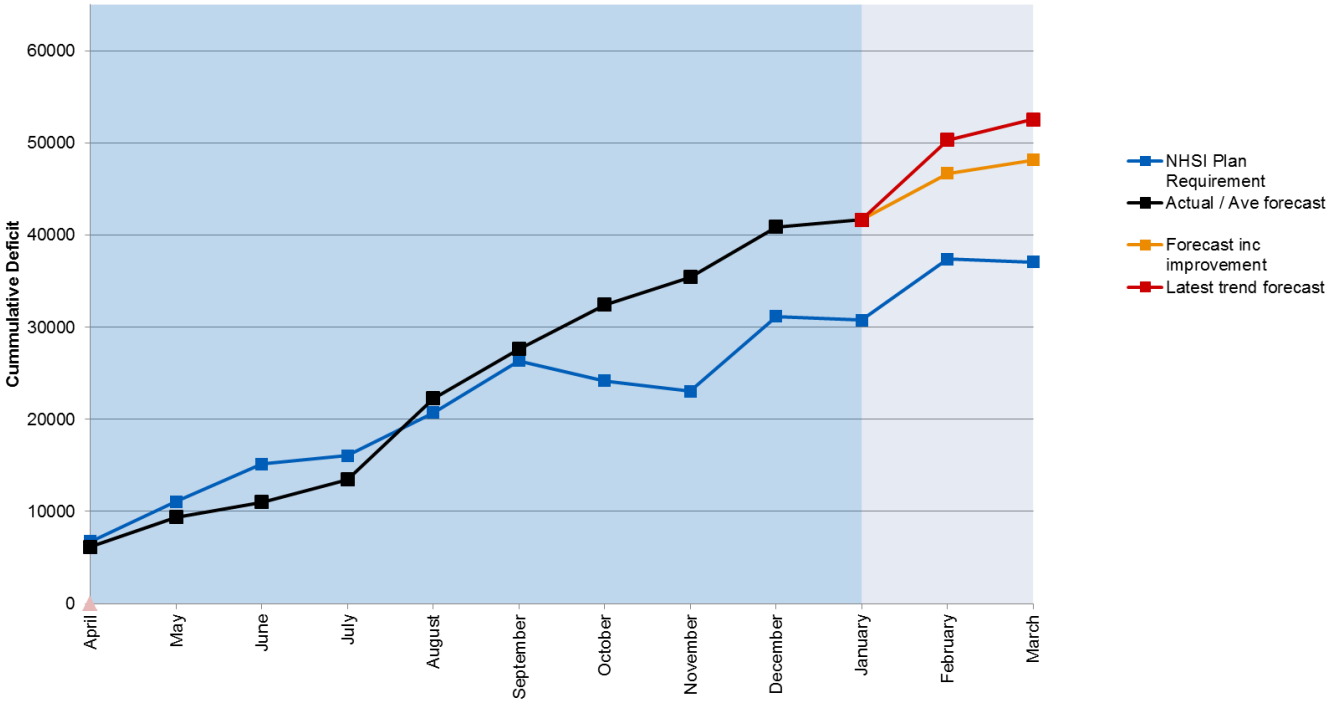
BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts, Chief Finance Officer
Paper prepared by:	Ursula Denton, Group Director of Finance
Date of paper:	13th February 2019
Subject:	Financial Performance for 2018/19
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Maintaining financial stability for both the short and medium term
Recommendations:	Hospitals/MCSs have taken specific further actions at the start of the fourth quarter, to build upon the recovery and improvement trajectories which were committed to in October for the third quarter and secure stronger, more consistent delivery of the required results. Follow up discussions continue to be held on a daily basis between the Group CFO, Group COO and Hospital CEOs to ensure that progress is maximised and any delay factors are systematically tackled and removed.
Contact:	Name: Adrian Roberts Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance for the ten months to January 2019 was **a bottom line deficit** (on a control total basis excluding Provider Sustainability Fund) **of £9.8m** (0.7**%** of operating income). The Trust delivered a surplus in January consistent with the plan submitted to NHS Improvement. This was underpinned by an improved performance across many of the Hospital financial results. This needs to be sustained into the final two months of the year in order to achieve the Trust's control total.
1.2	**Run Rate**	Sustained improvement in Hospital financial results over the remaining months of the fourth quarter is required. Focussed effort in reducing agency spending in the third quarter resulted in a reduced in-quarter overspend against the ceiling set by NHS Improvement. This has continued into January.
1.3	**Remedial action to manage risk**	Hospitals/MCSs have taken specific further actions at the start of the fourth quarter, to build upon the recovery and improvement trajectories which were committed to in October for the third quarter and secure stronger, more consistent delivery of the required results. Follow up discussions continue to be held on a daily basis between the Group CFO, Group COO and Hospital CEOs to ensure that progress is maximised and any delay factors are systematically tackled and removed.
1.4	**Cash & Liquidity**	As at 31st January 2019 the Trust had a cash balance of £116.2m.
1.5	**Capital Expenditure**	The Capital Plan for 2018/19 is £74.0m. Capital expenditure in the year to date was £40.3m against a plan of £64.6m. In light of the factors causing slippage over the early months, forecast spending to March 2019 has been reviewed and is significantly lower than plan.

Hospital Operating Financial Performance Projected to March



Financial Performance

Income & Expenditure Account for the period ended 31st January 2019

		Year to date - Month 10				
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to Month 9	Year to date Actual
INCOME	£'000	£'000	£'000	%	£'000	£'000
Income from Patient Care Activities						
A and E	45,379	37,923	373		295	38,296
Non-Elective (includes XBD's)	263,388	221,361	1,761		1,507	223,122
Elective (includes Day Case & XBD's)	213,805	178,328	-3,568		-2,662	174,760
Out-Patients (includes First & Follow up)	173,805	144,904	724		521	145,628
Other NHS Clinical Income	474,771	395,659	4,771		4,224	400,430
Community Services (includes LCO)	103,421	86,186	-1,043		-784	85,143
Drugs (excludes Blood Products)	105,319	87,767	-2,373		-1,359	85,394
Sub -total Income from Patient Care Activities	**1,379,888**	**1,152,128**	645	0.1%	1,742	**1,152,773**
Private Patients/RTA/Overseas(NCP)	8,135	6,753	1,691		1,273	8,444
Total Income from Patient Care Activities	**1,388,023**	**1,158,881**	2,336	0.2%	3,015	**1,161,217**
Training & Education	61,163	50,975	1,923		473	52,898
Research & Development	55,629	46,363	766		890	47,129
Misc. Other Operating Income	109,714	102,699	-12,177		-10,662	90,522
Other Income	**226,506**	**200,037**	-9,488	-4.7%	-9,299	**190,549**
Total Income	**1,614,529**	**1,358,918**	-7,152	-0.5%	-6,284	**1,351,766**
EXPENDITURE						
Pay	-917,483	-776,898	-14,211	-1.8%	-11,297	-791,109
Non pay	-634,454	-530,113	17,561	3.3%	14,522	-512,552
Total Expenditure	**-1,551,937**	**-1,307,011**	3,350	0.3%	3,225	**-1,303,661**
EBITDA Margin (excluding PSF)	**62,592**	**51,907**	-3,802	-7.3%	-3,059	**48,105**
Interest, Dividends and Depreciation						
Depreciation	-30,226	-25,227	3,032		2,744	-22,195
Interest Receivable	443	369	275		237	644
Interest Payable	-41,138	-34,454	108		91	-34,346
Dividend	-3,755	-2,500	506		1	-1,994
Surplus/(Deficit) on a control total basis	**-12,084**	**-9,905**	119	1.2%	14	**-9,786**
Surplus/(Deficit) as % of turnover						**-0.7%**
PSF Income	**44,931**					**24,113**
Non operating Income						**1,105**
Depreciation - donated / granted assets						**-615**
Impairment						**-16,486**
	32,847					**-1,669**

Operating Unit Performance against breakeven measures

Income	Pay	Non Pay	Trading Gap	Hospital	Variance to breakeven budgets - (adverse) / positive			Variance to Control Total		I&E Annual Turnover
Year to date variance					Year to date (to month 10)		Comparative position as at month 9	Control total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
2,222	-1,380	-1,841	-418	Clinical & Scientific Support	-1,417	-0.8%	-1,664	1,036	-2,453	224,315
2,409	7,181	-5,004	-2,302	Facilities, Research & Corporate	2,285	1.1%	558	0	2,285	260,097
1,066	2,610	-780	-807	Manchester LCO	2,089	2.7%	1,445	1,444	645	93,122
1,434	-9,587	-1,625	-22,985	MRI	-32,763	-10.8%	-29,387	-19,878	-12,885	363,003
669	940	13	-4,597	REH / UDH	-2,976	-4.5%	-2,640	-2,500	-476	78,563
793	-1,208	-340	0	RMCH	-755	-0.4%	-166	1,250	-2,005	224,835
1,272	246	-1,378	-2,841	Saint Mary's Hospital	-2,701	-2.0%	-2,336	-1,500	-1,201	162,293
-2,135	-2,566	3,525	-10,372	WTWA	-11,548	-3.5%	-12,841	-9,451	-2,097	399,399
7,731	**-3,764**	**-7,431**	**-44,322**	**Trust position**	**-47,786**	**-3.2%**	**-47,031**	**-29,599**	**-18,187**	**1,805,627**

Key Run Rate Areas

1. 2018/19 Trading Gap challenge

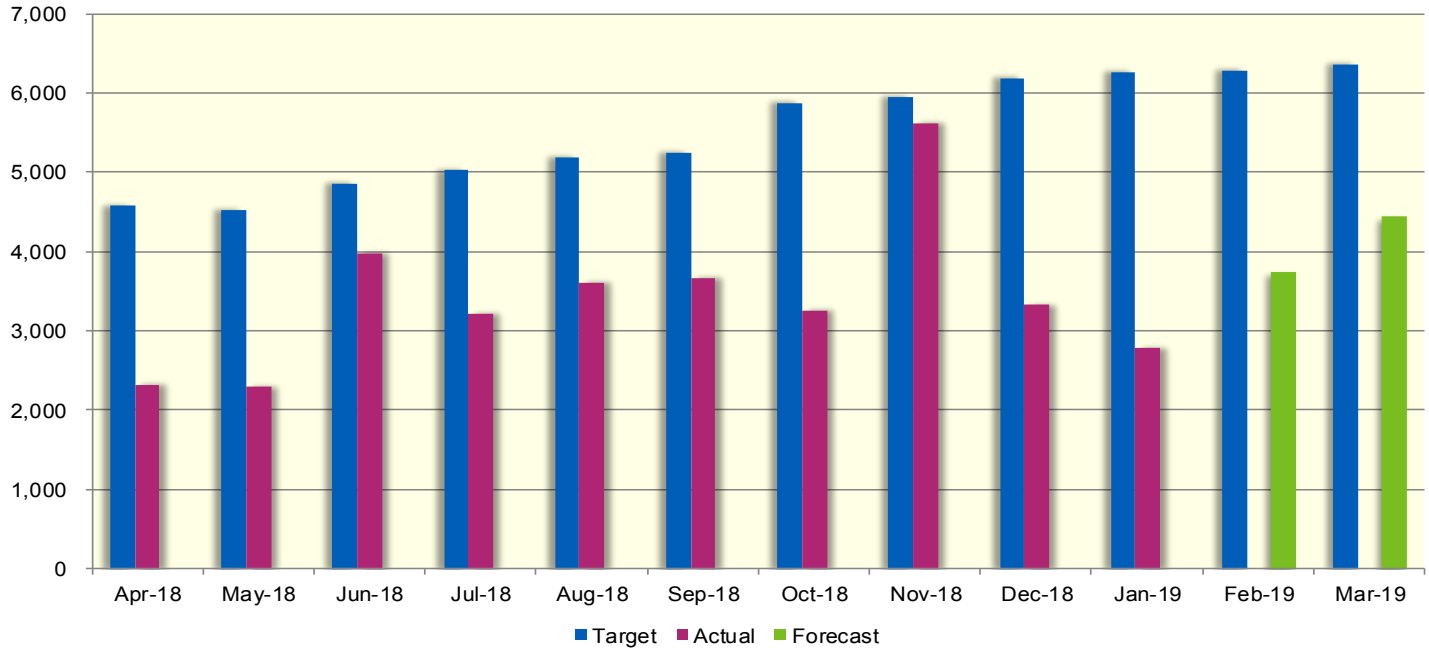
Theme Breakdown	Savings to date				Forecast to year-end			
	Target £'000	Achieved £'000	Variance £'000	Financial RAG	Target £'000	Forecast £'000	Variance £'000	Financial Forecast RAG
Admin and clerical	1,893	1,833	(61)	97%	2,289	2,219	(69)	97%
Blood Management	12	3	(8)	29%	14	5	(9)	35%
Contracting & income	6,319	5,773	(547)	91%	7,696	7,029	(667)	91%
Hospital Initiatives	4,975	5,989	1,014	120%	6,536	7,629	1,093	117%
Length of stay	33	13	(20)	0%	50	20	(30)	40%
Outpatients	1,478	1,040	(438)	70%	1,782	1,300	(482)	73%
Pharmacy and medicines management	1,495	1,204	(291)	81%	1,885	1,452	(433)	77%
Procurement	4,085	3,040	(1,045)	74%	5,292	4,062	(1,229)	77%
Theatres	2,113	1,575	(538)	75%	2,742	2,048	(694)	75%
Workforce - medical	4,522	3,395	(1,127)	75%	5,714	4,277	(1,436)	75%
Workforce - nursing	1,359	1,213	(146)	89%	1,738	1,593	(146)	92%
Workforce - other	675	1,139	464	169%	725	1,189	464	98%
Full year effect of prior year schemes	7,897	7,897	(0)	100%	9,476	9,476	(0)	100%
Unidentified	17,155	0	(17,155)	0%	20,586		(20,586)	0%
Grand Total	**54,010**	**34,112**	**(19,898)**	**63%**	**66,525**	**42,300**	**(24,225)**	**64%**

Financial RAG

The RAG Rating in the table above is the overall financial risk rating based on the criteria defined below. There are many individual schemes within each main savings theme, and at a detailed level there will be a range of ratings within each theme.

- Financial Delivery less than 90%
- Financial Delivery greater than 90%, but less than 97%
- Financial Delivery greater than 97%

Trading Gap Target and Achievement /Forecast by Month



Narrative:

The year-to-date Trading Gap position includes £7.7m of non-recurrent items. The split across the months of the year is outlined below:

April - £550k
May - £422k
June - £1,237k
July - £761k
August - £421k
September - £949k
October - £533k
November - £1,696k
December - £569k
January - £554k

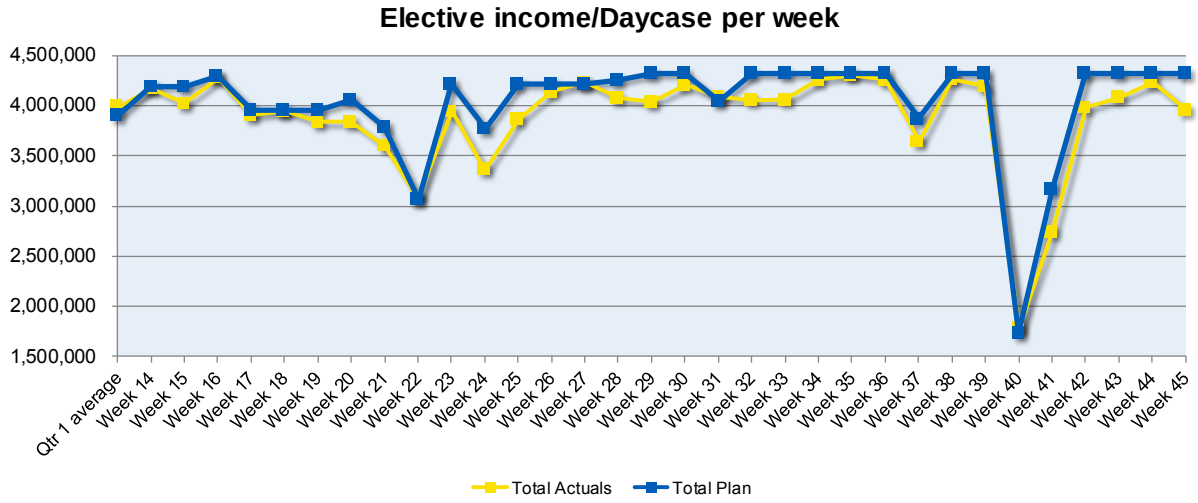
2. Agency spend by Hospital / MCS

Staff Group	YTD M1-10 £'000s	Average m1-6 £000's	Average m7-9 £000's	Month 10 £000's
Consultant	-4,172	-452	-438	-132
Career Grade Doctor	-460	-48	-52	-17
Trainee Grade Doctors	-6,087	-685	-571	-265
Registered Nursing Midwifery	-7,223	-772	-637	-686
Support to Nursing	-1,361	-137	-150	-84
Allied Health Professionals	-1,352	-177	-93	-14
Other Scientific and Theraputic	-1,778	-177	-206	-98
Healthcare Scientists	-1,331	-164	-81	-100
Support to STT / HCS	-893	-89	-106	-37
Infrastructure Support	-942	-85	-90	-176
Grand Total	**-25,599**	**-2,786**	**-2,424**	**-1,609**

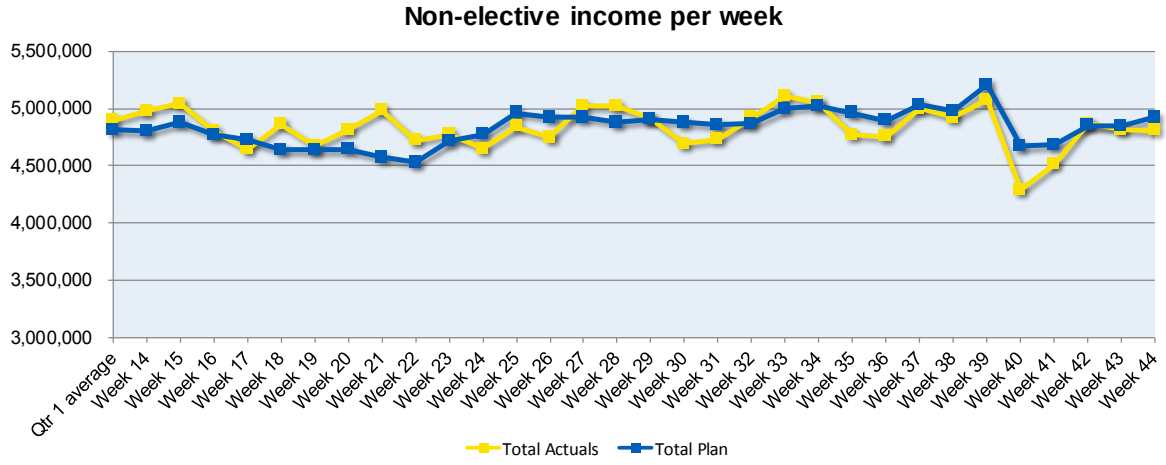
Hospitals	YTD M1-10 £'000s	Average m1-6 £000's	Average m7-9 £000's	Month 10 £000's
Clinical & Scientific Support	-3,714	-444	-301	-131
Manchester LCO	-472	-47	-44	-55
MRI	-8,510	-924	-859	-389
REH / UDH	-1,102	-111	-117	-83
RMCH	-1,489	-144	-157	-152
Saint Mary's Hospital	-353	-36	-30	-46
WTWA	-8,016	-899	-697	-531
Corporate	-1,708	-164	-179	-209
Research	-235	-17	-40	-13
Total	**-25,599**	**-2,786**	**-2,424**	**-1,609**

	Agency spend M1-10 (£000)	Agency ceiling M1-10 (£000)	Difference (£000)	% Above Ceiling
Trust Total	**-25,599**	**-22,100**	**-3,499**	**15.8%**

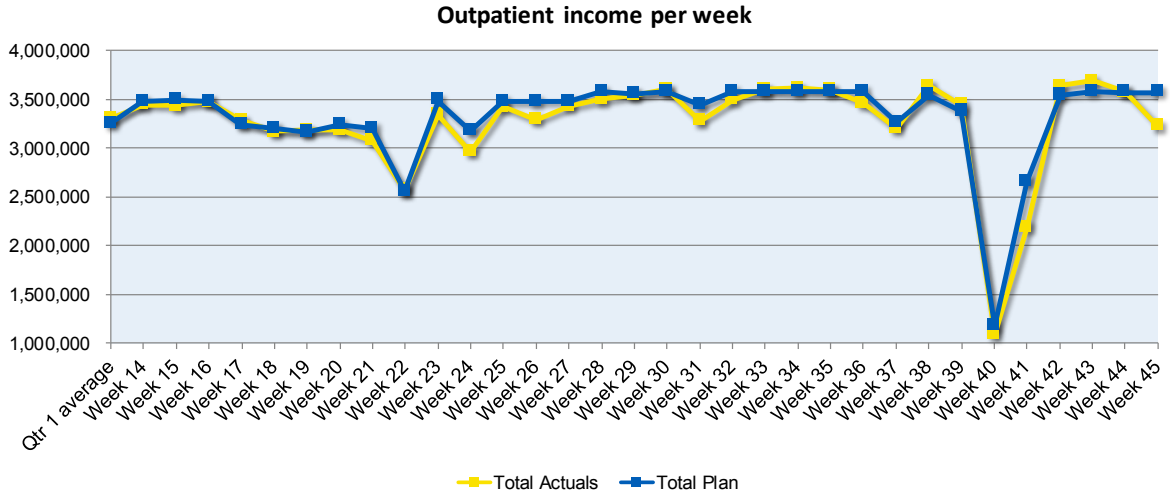
3. Elective / Daycase income: January 2019



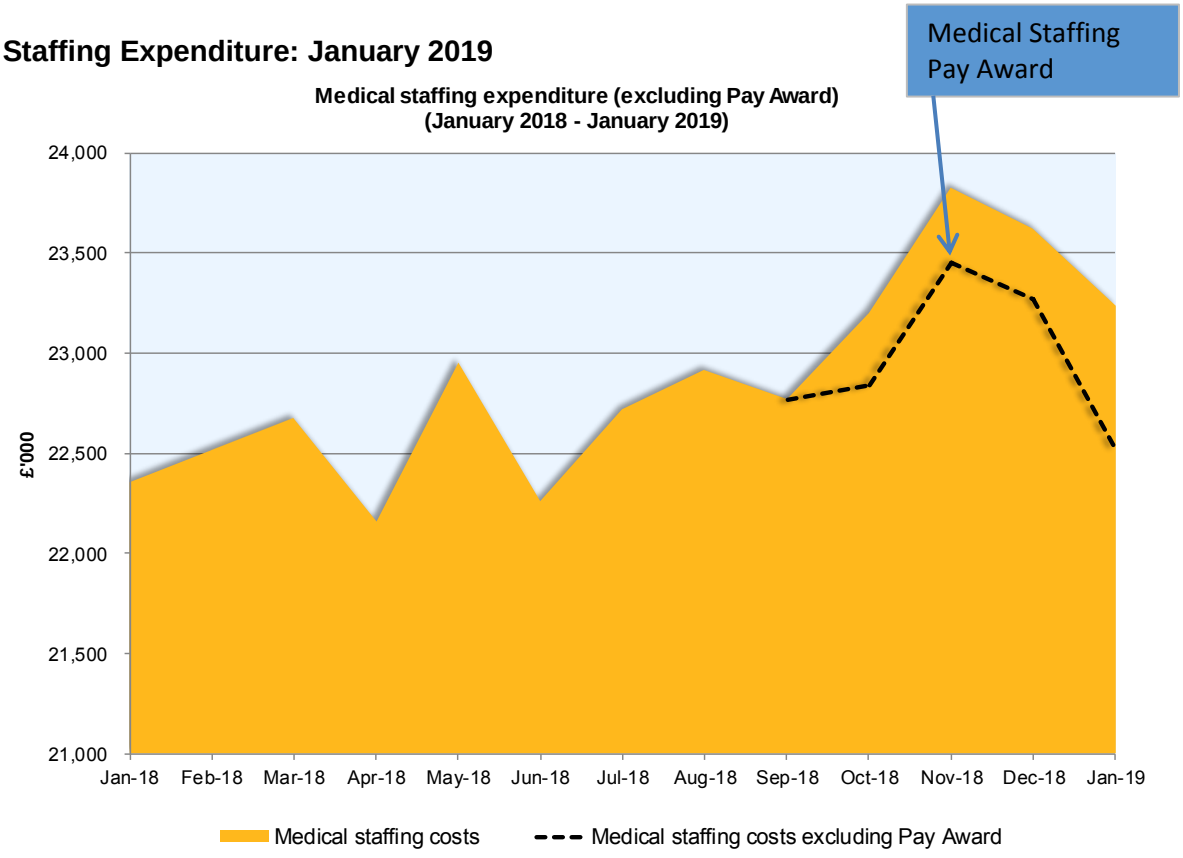
4. Non-Elective income: January 2019



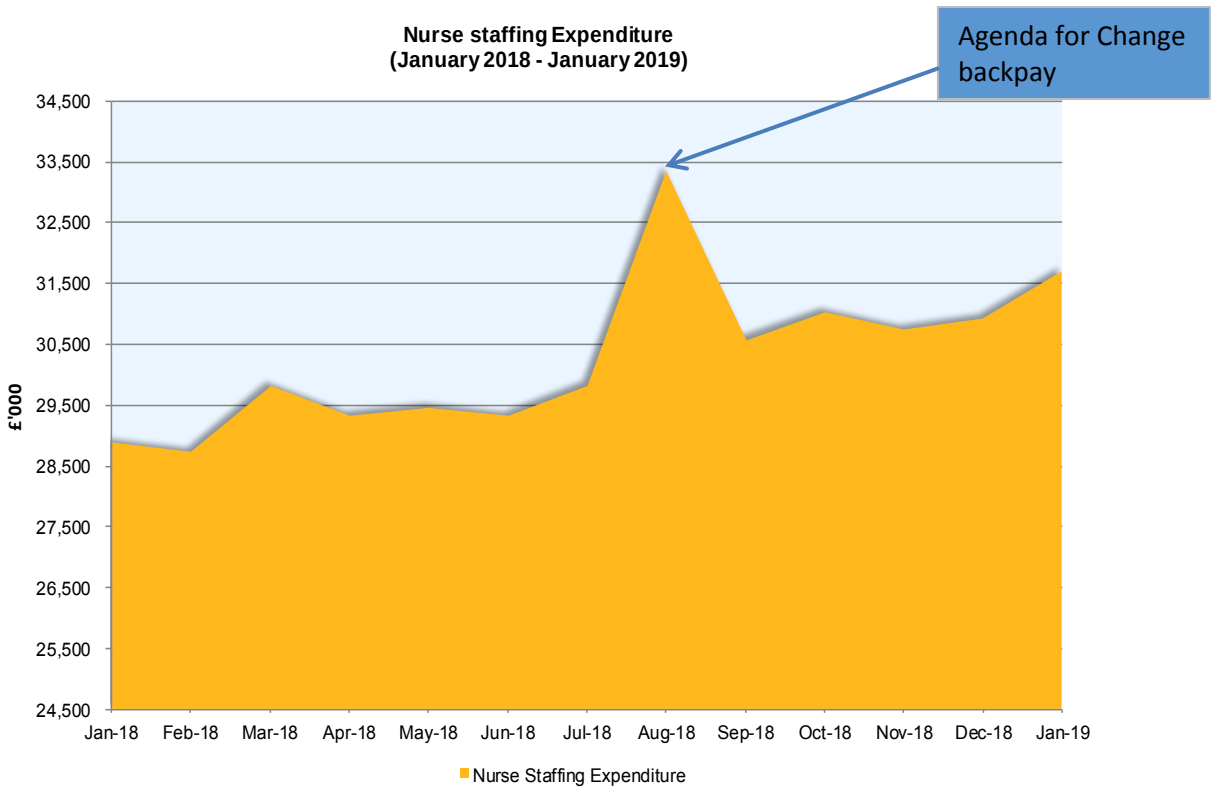
5. Outpatient income: January 2019



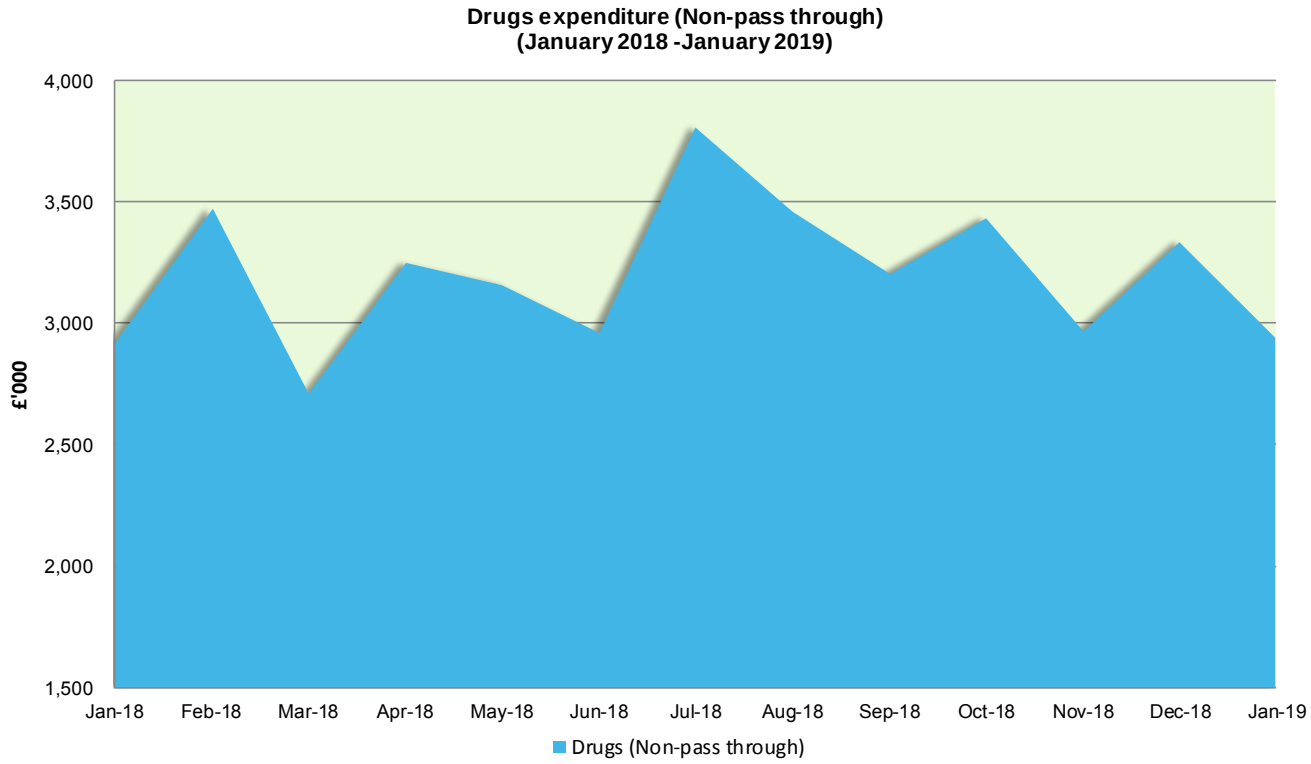
6. Medical Staffing Expenditure: January 2019



7. Nurse staffing Expenditure: January 2019



8. Prescribing Drugs: January 2019



NHS Improvement's KPIs

	Plan YTD		Actual YTD	
	Metric	*Level*	*Metric*	*Level*
Liquidity ratio	(0.2)	2	0.5	1
Capital servicing capacity	1.6	3	1.3	3
I&E Margin	1.8%	1	1.0%	1
I&E margin: Distance to financial plan	0.0%	1	(0.8%)	2
Agency spend Metric - above / (below) the agency ceiling	8.7%	2	15.8%	2
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

	Annual Plan (full year)		Forecast 18/19	
	Metric	*Level*	*Metric*	*Level*
Liquidity ratio	0.2	1	(0.6)	2
Capital Servicing Capacity	1.6	3	1.4	3
I&E Margin	2.0%	1	1.2%	1
I&E margin: Distance to financial plan	0.0%	1	(0.8%)	2
Agency spend Metric - above / (below) the agency ceiling	8.1%	2	15.3%	2
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

Narrative:

Under the Use of Resource (UOR) metrics, the Trust achieves an overall level 2.

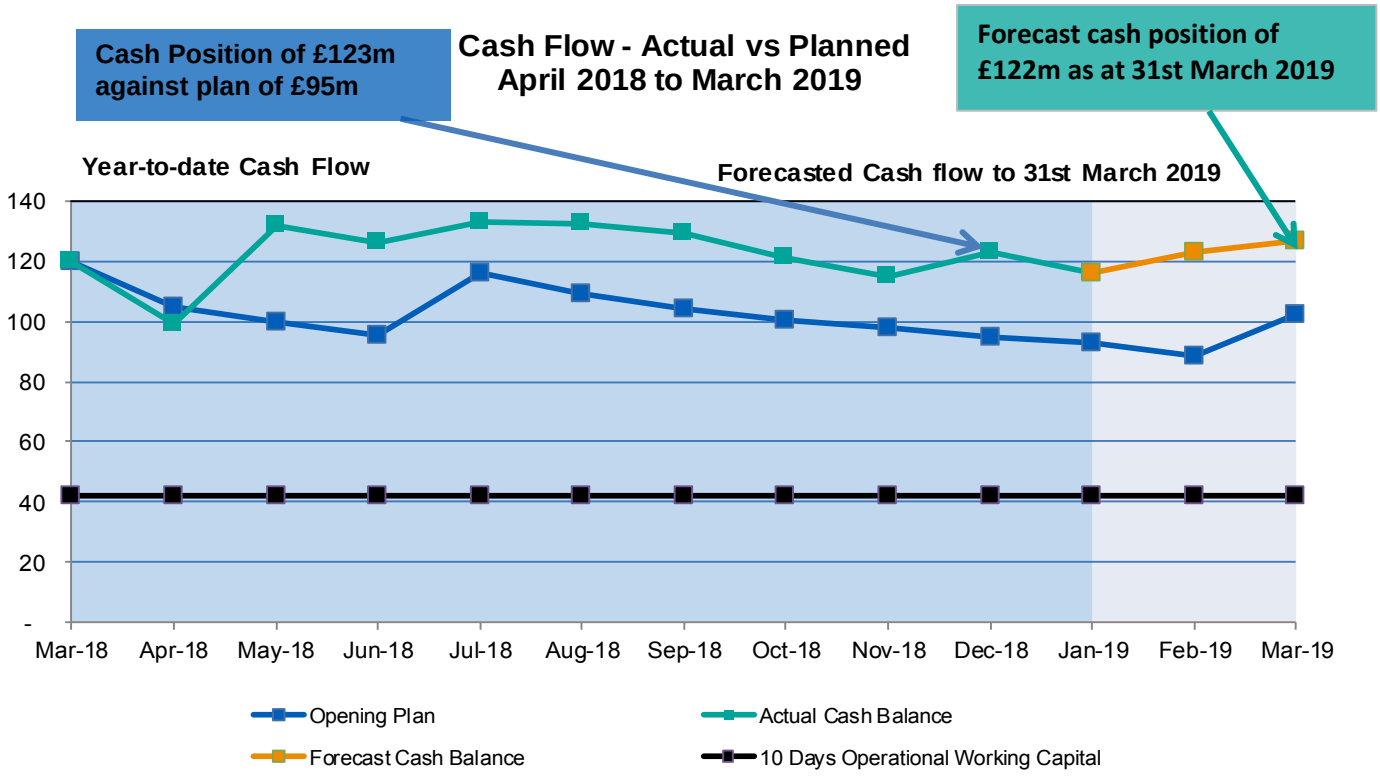
Two elements are driving adverse variances to the plan submitted to NHSI:

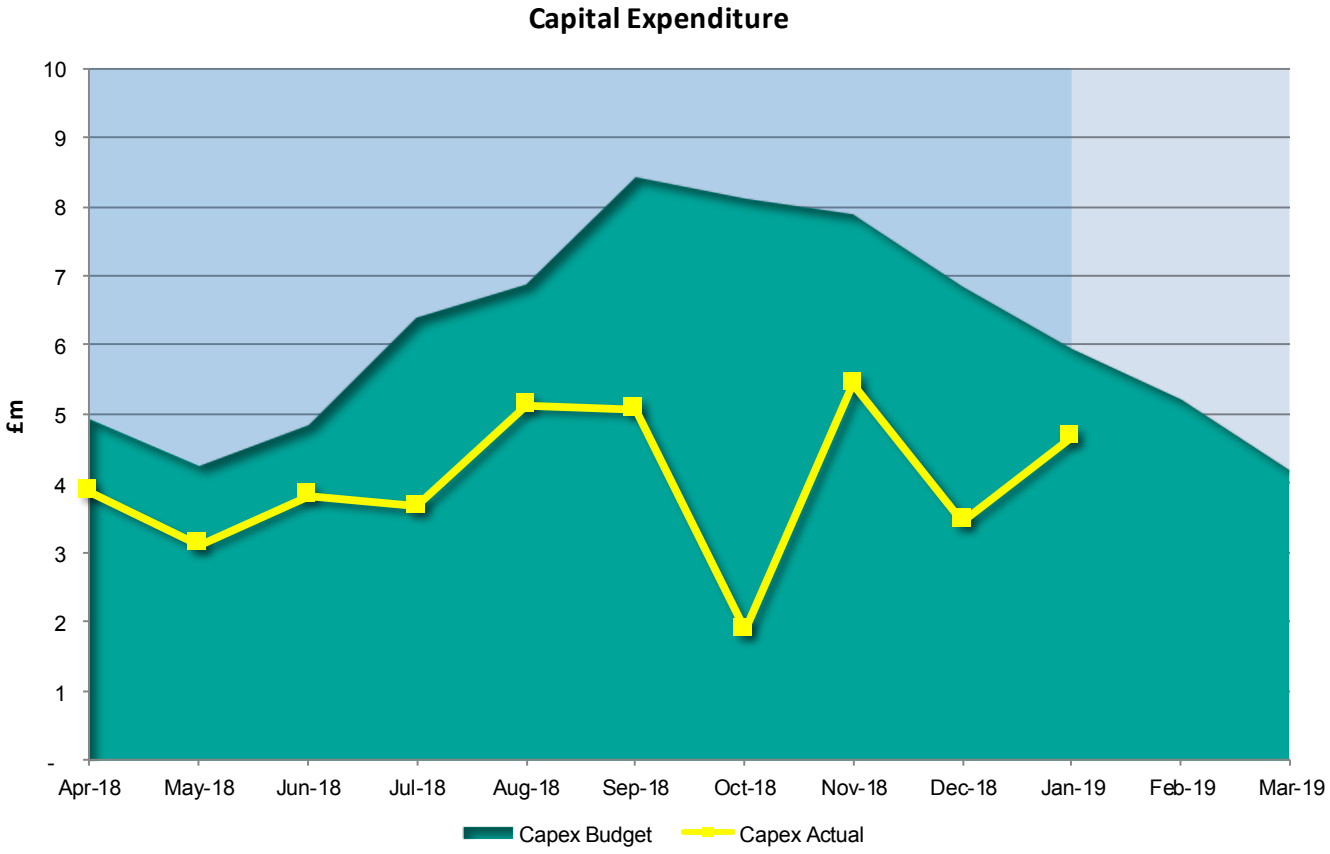
- Agency spend – since October, monthly average expenditure on agency staff has decreased by over £0.5m. This is an improvement compared to months 1-6 where the Trust exceeded its ceiling by 26%.
- The loss of the Provider Sustainability Fund associated with A&E performance is driving a deterioration in the I&E margin scores.

Balance Sheet

	Opening Balance Sheet 01/04/2018 £000	Actual Year to Date 31/01/2019 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,397	3,298	(1,099)
Property, Plant and Equipment	617,672	619,777	2,105
Investments	866	866	0
Trade and Other Receivables	5,591	6,778	1,187
Total Non-Current Assets	**628,526**	**630,719**	**2,193**
Current Assets			
Inventories	17,026	15,845	(1,181)
NHS Trade and Other Receivables	90,505	90,962	457
Non-NHS Trade and Other Receivables	41,863	37,275	(4,588)
Other Current Assets	0	0	0
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	119,896	116,178	(3,718)
Total Current Assets	**269,500**	**260,470**	**(9,030)**
Current Liabilities			
Trade and Other Payables: Capital	(9,497)	(3,633)	5,864
Trade and Other Payables: Non-capital	(154,265)	(172,519)	(18,254)
Borrowings	(22,286)	(21,827)	459
Provisions	(23,052)	(18,293)	4,759
Other liabilities: Deferred Income	(22,635)	(26,068)	(3,433)
Other Liabilities: Other	0	0	0
Total Current Liabilities	**(231,735)**	**(242,340)**	**(10,605)**
Net Current Assets	**37,765**	**18,130**	**(19,635)**
Total Assets Less Current Liabilities	**666,291**	**648,849**	**(17,442)**
Non-Current Liabilities			
Trade and Other Payables	(2,601)	(2,600)	1
Borrowings	(423,858)	(408,161)	15,697
Provisions	(7,251)	(8,955)	(1,704)
Other Liabilities: Deferred Income	(5,252)	(3,133)	2,119
Total Non-Current Liabilities	**(438,963)**	**(422,849)**	**16,114**
Total Assets Employed	**227,328**	**226,000**	**(1,328)**
Taxpayers' Equity			
Public Dividend Capital	203,291	203,631	340
Revaluation Reserve	45,408	45,408	(0)
Income and Expenditure Reserve	(21,371)	(23,039)	(1,668)
Total Taxpayers' Equity	**227,328**	**226,000**	**(1,328)**
Total Funds Employed	**227,328**	**226,000**	**(1,328)**

Cash flow and capital expenditure





Scheme	Plan £'000	Plan YTD at 31st Jan 2019 £'000	Spend YTD at 31st Jan 2019 £'000	Spend in future months £'000	Forecast Year End £'000
Property and Estates schemes					
Helipad	5,246	5,175	380	120	500
Diabetes Centre	1,849	1,849	22	178	200
Emergency Department - Wythenshawe	5,548	4,623	4,734	1,624	6,358
MRI ED redevelopment	3,992	3,162	616	134	750
RMCH ED redevelopment	1,000	833	0	0	0
Property & Estates Schemes - Compliance Work	18,534	16,174	10,671	4,376	15,047
Property & Estates Schemes - Development	11,862	10,398	3,709	1,499	5,208
Property & Estates - sub-total	**48,031**	**42,214**	**20,132**	**7,931**	**28,063**
IM&T schemes					
Electronic Patient Records (EPR)	2,100	1,750	1,076	1,104	2,180
IM&T Rollng Programme	1,555	1,369	1,200	226	1,426
IM&T Strategy	7,949	7,459	5,912	1,867	7,779
IM&T - sub-total	**11,604**	**10,578**	**8,188**	**3,197**	**11,385**
Equipment rolling replacement programme	**6,904**	**5,598**	**5,584**	**3,494**	**9,078**
PFI Lifecycle	**7,500**	**6,250**	**6,398**	**1,166**	**7,564**
Total expenditure	**74,039**	**64,640**	**40,302**	**15,788**	**56,090**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Darren Banks,Group Executive Director of Strategy
Date of paper:	21 February 2019
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the report including: - National issues - Greater Manchester issues - Progress on the development of the MFT service strategy programme.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

The purpose of this paper is to update the Board of Directors in relation to strategic issues of relevance to MFT.

2. National Issues

Planning Guidance

Full guidance was published by NHSE and NHSI in early January for the 2019/20 Operational Plan submissions. The draft narrative and financial templates were submitted on 12 February and we are now awaiting feedback from NHS I. The final versions must be submitted by 4 April 2019.

Local Specialised Commissioning boards

As part of the 2019/20 planning guidance, NHS England have announced plans for the integration of specialised services with local health and care systems. The move will see local systems and national commissioners working together to plan services and develop place-based commissioning. Services for rare conditions which serve populations over 10 million would remain nationally or regionally commissioned as shown in the table below.

For services which cover a population of less than ten million, NHSE intend for specialised activity to be commissioned via new joint planning boards. There is a minimum expectation that by April 2019 all STPs/ICSs will have established or begun to set up a joint planning board, with some locally led and others led by NHSE. Core membership should include; STP/ICS representation (commissioner and provider); NHSE specialised commissioners; clinicians and patient/public lay members.

More mature systems will be allowed to develop more advanced place-based specialise commissioning arrangements. These systems will be expected to build a case for change, develop proposals, implement new arrangements and then evaluate outcomes. Proposals will however need to be signed off by the relevant NHSE authority.

Table 1: Summary segmentation of specialised services

Commissioning levels	Population size	Services	Examples	Possible practical application
National or regional	Over 10m population	~80 services ~£1.6bn	Proton beam therapy, specialist mental health services for deaf adults	Remain nationally or regionally commissioned, working with local systems as appropriate
Sub-regional	2.5m - 10m population	~50 services ~£8.6bn	Radiotherapy, children's specialist surgery, CAMHS Tier 4	Greater collaboration with local systems through planning boards
Local health systems (STP/ICS or groups of STPs/ICSs)	1m - 2.5m population	~20 services ~£6.4bn	Adult specialist cardiac services, renal dialysis, chemotherapy	Greater collaboration with local systems

With the current legislative framework NHSE retains formal responsibility for the commissioning of specialised services. However NHSE have identified three options which are possible within the current legislative framework to support better integration of specialised commissioning with local systems:

- Pooled budgets: NHSE and CCGs to share incentives, risk and decision-making
- Joint appointments: between NHSE regional specialised commissioners and local commissioners at the system or place level to effectively enable more localised decision making
- Internal delegation of specialised commissioning – model used in GM where the Chief Officer is an NHSE employee.

We are awaiting further information from NHSE in the form of readiness criteria to determine whether systems should pursue these advanced arrangements, and will need to work though how this could affect services across the North West and Greater Manchester.

3. Greater Manchester Issues

Improving Specialist Care Programme

The Theme 3 programme has been renamed the "Improving Specialist Care Programme". The proposed Models of Care for Breast, Orthopaedics, Urology, Vascular, Paediatric surgery, Cardiology and Respiratory services are undergoing analytical modelling by McKinsey & Co. This work is expected to conclude at the end of Q4 2018/19.

PET CT

In partnership with The Christie NHS FT, and as part of a national contract award by NHS England, MFT will be part of the 'One Manchester' PET CT project, which will see PET CT capacity across Greater Manchester increase significantly over the next 7 years. As well as increasing diagnostic capacity across the city region, the service aims to increase access to PET CT in areas that are currently under-served. The contract is due to start from 1 April 2019.

4. MFT Issues

Service Strategy Development

Overarching group service strategy

Following approval of the overarching Group Service Strategy by the Board of Directors in November 2018, we are now seeking the views of external stakeholders, in particular commissioners and those involved in its development. Internally communications are being cascaded through the usual engagement mechanisms such as iNews and Hospital / MCS staff forums.

The document will remain a 'live' working document until completion of Waves 2 and 3, and the Managed Clinical Services (MCS) strategies so that it can be updated to reflect any feedback received and to capture the outputs from the whole programme.

Clinical service strategies

Wave 1

The Wave 1 clinical service strategies were reviewed by the Board in February. The Wave 2 service strategies are now complete and are progressing through the approval process. The Wave 3 clinical strategy programme has commenced and is planned to conclude in May 2019, with presentation to the Board in July.

The development of the Managed Clinical Services (Children's, Saint Mary's, Eye and Dental) strategies is on-going. They are planned to be complete by mid-April and to be presented to the Board in May 2019.

The proposals outlined in the strategies are at a formative stage and we are now about to engage with commissioners on the next steps.

Trafford Community Services

MFT has received confirmation that it has been chosen as the preferred provider for Trafford Community Services following an external tender process. For the past five years, Trafford Community Services have been delivered by Pennine Care NHS Foundation Trust. However, Pennine Care issued notice on its contract to provide these services in October 2018. MFT has been chosen as the preferred provider following a meeting of the Trafford procurement moderation panel in December 2018. The due diligence process is now underway.

5. Actions / Recommendations

The Board of Directors is asked to note the report including:

- National issues
- Greater Manchester issues
- Progress on the development of the MFT service strategy programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Director of Strategy
Date of paper:	20 February 2019
Subject:	NHSI Operational Plan
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to: • Note the draft Operational Plan narrative was submitted to NHSI/E on 12 February 2019 • Note the further work to be undertaken • Approve the proposal to delegate sign off of the NHSI/E Operational Plan narrative to the Chair and Chief Executive.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

NHSI Operational Plan 2019/2020

1. Introduction

The purpose of this paper is to update the Board in relation to the NHSI/E Operational Plan for 2019/20 and request approval for delegated sign off by the Chair and Chief Executive.

2. Background

For 2019/20 NHS I/E require a MFT level operational plan. The plan is made up of:

- A number of templates including:
  - Financial plan
  - Activity plan and performance trajectories
  - Workforce plan
  - Triangulation form
- A narrative document.

It should be noted that this is a technical document that we are required to submit to NHS I/E, and not the MFT Annual Plan.

The financial, activity and performance, workforce and triangulation templates are completed by Finance and approved by the Finance Scrutiny Committee.

This paper relates to the narrative document only.

3. Operational Plan Narrative Requirements

NHS I/E are prescriptive in their requirements for the narrative; it must cover the following:

- Activity – activity over the next year based on demand and capacity modelling and lessons from previous years' winter and system resilience planning.
- Quality – outline of the approach to quality covering; quality improvement, leadership and governance, the quality improvement plan and impact assessment process.
- Workforce – workforce challenges, risks and long term vacancies.
- Financial – financial forecasts and modelling, efficiency savings for 2019/20, agency rules and capital planning.
- Link to Sustainability and Transformation plan – how the local ICS/STP vision is being taken forward by providers and effect on the MFT operational plan.
- Membership and elections – election information; governor recruitment, training and development work.

The deadlines for submission of the narrative are set out below:

Submission requirement	**Deadlines**
First draft	12 February 2019
Final version	4 April 2019

4. Greater Manchester Alignment

Greater Manchester Health & Social Care Partnership team have submitted GM level plans. There has been no reconciliation of the GM level plans with provider plans at this stage, the focus to date has been on ensuring alignment across CCGs and provider plans. Triangulation across GM, CCG and provider plans will take place prior to the deadline for final submissions.

5. MFT Operational Plan Narrative

The draft MFT Operational Plan narrative (attachment A) was submitted for the 12 February deadline and we are now awaiting feedback from NHSI/E. Feedback is expected by 29 March 2019, just 4 working days in advance of the deadline for submission of the final document.

An updated version of the narrative, which will reflect any feedback received and further work to ensure that a consistent narrative flows through the document, will be completed by 1 April in line with submission on 4 April 2019.

As the next meeting of the Board of Directors meeting is on the 8 April, we are asking the Board to approve delegation of the sign off of the plan to the Chair and CEO in order to meet the NHSI deadline.

6. Actions / recommendations

The Board of Directors is asked to:

- Note the draft Operational Plan narrative was submitted to NHSI/E on 12 February 2019
- Note the further work to be undertaken
- Approve the proposal to delegate sign off of the NHSI/E Operational Plan narrative to the Chair and Chief Executive.

Agenda item 9.2

Attachment A

Manchester University NHS Foundation Trust

Operational Plan 2019-2020

Contents

1. Introduction

Manchester University NHS Foundation Trust (MFT) was created on 1 October 2017 through the merger of Central Manchester University NHS Foundation Trust (CMFT) and University Hospital of South Manchester (UHSM). It is one of the largest NHS trusts in England providing community, secondary, tertiary and quaternary services to the populations of Greater Manchester and beyond. With a workforce of over 20,000 staff, we are the main provider of hospital care to approximately 750,000 people in Manchester and Trafford and the single biggest provider of specialised services in the North West of England. We are a university teaching hospital with a strong focus on research and innovation.

The Trust is responsible for running a group of nine hospitals across six distinct geographical locations and for hosting the Manchester Local Care Organisation (MLCO). MFT has eight operational units; five of these are described as Managed Clinical Services, two are hospitals and one is the hosted MLCO. The five Managed Clinical Services are accountable for the delivery and management of a defined group of clinical services taking place on any site within MFT. Their role includes the operation of Clinical Standards Groups for their areas of specialty, setting clinical standards and developing evidence-based guidelines and pathways across the Trust.

The other two operational units are the hospital sites of Manchester Royal Infirmary (MRI) on the Oxford Road campus, and the multiple hospital sites of Wythenshawe, Trafford General, Withington and Altrincham Hospitals (WTWA) managed by the senior leadership team based out of Wythenshawe Hospital. The two operational units of MRI and WTWA each deliver many clinical services to adults which they share in common, such as Emergency Medicine, Urology and Cardiac Surgery, but which are operationally managed independently by each site.

The organisation structure also takes into account MLCO and provision of community services. MFT is a key partner in the LCO that is providing integrated out-of-hospital care in the city of Manchester. Services provided incorporate community nursing, community therapy services, intermediate care and enablement, and some community-facing general hospital services. The overall organisational structure of MFT is illustrated in the diagram found in Appendix 1.

In addition to being a new organisation, MFT was formally and legally constituted as a ‘Group’. This required a new design of Executive oversight and leadership. MFT designed a structure that starts with the delivery of clear, vertical operational grip to ensure patient safety and maintain clear accountability. This is achieved through the management of the Hospital Sites and Managed Clinical Services as operational units, each with their own Chief Executive and leadership team. These operational units are overseen by the Group Chief Operating Officer with Chief Executives reporting to the Group Chief Executive. The Clinical Standards Groups bring together a multi-disciplinary group of subject experts and supporting professionals to enable clinical staff to apply best practice and standardisation across the Trust. In addition, Education and Research runs through the whole structure.

2. Quality Planning

The MFT Quality and Safety Strategy (2018-2021) sets out the priorities, principles and ambitions for providing high-quality services over the next three years and, therefore, delivering our vision and objectives. The Quality and Safety Strategy is central to the work of the Trust and aligns closely with other core strategies such as the Leadership and Culture Strategy and the Trust Values and Behaviours. Our aim is to apply clinical and academic research, education and teaching to the delivery of care; provided by people with the right skills, knowledge, attitude and behaviours. The Strategy provides an overarching framework for a number of work programmes across the Trust and is underpinned by the Trust's vision, strategic aims and values.

The Quality and Safety Strategy sets out the following broad commitments for 2018/21, the detail of which will inform the quality priorities for the year:

SAFE	Right care, first time, every time
CARING	Providing the quality of care that matters to patients, carers and families
EFFECTIVE	Best outcomes for every patient
RESPONSIVE	Hearing the patient, public and staff voice at every level of the organisation
WELL-LED	Exemplary leadership at all levels

A fundamental aspect of delivering the key priorities is ensuring there is sufficient Quality Improvement (QI) capacity and capability across the Trust, this will be achieved by:

- Increasing the QI expertise within the Trust's Quality Improvement Team and across the Group
- Ensuring that the Trust's QI methodology; the Improving Quality Programme (IQP) is understood by frontline staff
- Sharing and spreading best practice from improvement work and outcomes of accreditations of clinical areas at scale
- Supporting the Trust values and upholding high standards of professional practice

The Trust is committed to understanding quality and safety performance through the effective measurement of and response to evidence based metrics. These metrics along with other information sources, such as patient and staff feedback, will be used to monitor the delivery and impact of the Quality and Safety Strategy throughout the year. Key quality and safety metrics are reflected in the Trust's Accountability Oversight Framework (AOF) to support monitoring and continuous improvement at a Hospital/MCS level. The AOF sets out a number of metrics across six domains: Safety; Patient Experience; Finance; Operational Excellence; Workforce and Leadership and Strategy

The assessments against these domains inform the score which in turn informs the decision-making rights of a Hospital or MCS. In addition, performance against identified quality and safety metrics is reviewed at all levels of the organisation including the Group Quality and Safety Committee and the Board of Directors. The safety metrics used are based on the model 'Measurement and Monitoring of Safety', developed by the Health Foundation, and fall into five broad categories:

1. Has patient care been safe in the past?
2. Are our clinical systems and processes reliable?
3. Is care safe today?
4. Will care be safe in the future?
5. Are we responding and improving?

As a new organisation, MFT underwent a comprehensive CQC inspection in Q3 2018/19 as per the CQC regulations; findings are awaited. We aimed to achieve a good or outstanding rating across all of our services, but were however clear about the risks to quality faced and how they are managed. The action plans arising from the CQC inspection will be a significant component of the Trust quality improvement plan in 2019/20. The Trust will continue to be responsive to the recommendations of internal and external quality reviews and inspections.

Management of Risk

The Group Risk Management Committee oversees the management of all high level risks to the delivery of the organisational strategic aims and key priorities and these are mapped on the Board Assurance Framework. A thematic review of current risks on the Trust's risk register highlights the following three overarching risks to clinical quality:

- **Demand** – maintaining and improving the quality of clinical services with an increasing demand on services
- **Clinical systems** – communication of diagnostic and screening test results, trauma and orthopaedic service review and Never Events
- **Service Development and Finance** – maintaining and improving the quality of clinical services within the current financial constraints and safe acquisition of other services

Risks that present a significant threat to the Trust objectives or that score 15+ are reported bi-monthly to the Group Risk Management Committee. Detailed plans are in place to mitigate against these risks.

Accountability

The primary mechanism for feedback on the progress of the Quality and Safety Strategy to stakeholders is our Quality Report, which is published annually as per statutory requirements.

All functions of the organisation play a role in the improvement of quality. However, there are a number of key committees and functions which oversee more explicitly the delivery of the Quality and Safety Strategy. The Quality and Safety Committee (jointly chaired by the Group Joint Medical Directors and Group Chief Nurse) is the main committee where progress is monitored. This committee reports to the Trust's Board of Directors via the Group Management Board, so there is a clear line of accountability. Additionally MFT has a Quality and Performance Scrutiny Committee, chaired by a non-executive director, at which Board members can drill down into the detail of particular metrics and hold the executive directors to account.

Whilst all executive directors have responsibility for the delivery of quality improvement, the named executive leads for quality are the Group Joint Medical Directors and Group Chief Nurse. Their clinical quality objectives for 2019/20 are set out in the Quality and Safety Strategy.

MFT Quality Improvement Plan

The inception of MFT has heralded a new and innovative approach to designing services to improve the quality of care, for the people of Manchester, Trafford and beyond. Existing and new quality improvement plans to address the following will be delivered and further enhanced through the year:

- Improvements to the management of and response to national clinical audits
- Work to improve the management and communication of diagnostic tests and results
- Improvement work on invasive procedures and the safety mechanisms in place
- Continue to work to improve the care experience of patients with a mental health diagnosis
- Continue to review our approach to management of and learning from serious incidents
- Monitoring, acting on and learning from incidents and near misses
- A programme of work will continue to strengthen mortality review
- We will continue to act on national guidance and ensure that we implement evidence-based, best practice to improve outcomes, such as NCEPOD, NICE and national audit reports.
- Focus on harmonisation of work to improve End of Life Care across the Trust sites
- Reducing harm will continue to be a focus of improvement work across the Trust;
- CQUINS for 2019/20 are being discussed with commissioners.
- The Trust will continue the programme of work undertaken on sepsis over the past two to three years to raise awareness, early detection and treatment of sepsis within A&E and other clinical areas.
- Following the publication of the 'Better Births' Report, a Transformation Board is in place for Greater Manchester and Eastern Cheshire to support the implementation of actions in response to the recommendations of the review.

Seven day services

Both legacy trusts were early implementer sites and following the merger worked as a single organisation to deliver the 7 Day Services standards for urgent and emergency care as well as participating in the twice yearly national self-assessment survey administered by NHSE. Moving into 2018-19 NHSI has replaced the twice yearly national audits with a Board Assurance Tool which is being piloted prior to a full implementation. MFT has added the delivery of the 7 day services standards to Trust's Accountability Oversight Framework to support monitoring and continuous improvement at a Hospital/MCS level. A 7 Day Services Assurance Group is in place to deliver a collaborative approach so that bests practice and leaning can be shared across Hospitals/MCS.

This group has responsibility to assure the Board of Directors that the Hospitals/MCS have plans in place to deliver the ten standards ahead of the national target date of April 2020.

Quality Impact Assessment

The Trust Turnaround programme uses tools and templates prescribed by NHSI to assess the potential impact of projects on clinical quality and safety, clinical outcomes and patient experience. For the development and implementation of Turnaround project plans, the Trust uses a five step process which moves from idea generation, through project planning to delivery. Details of the Trust's approach to project planning, QIAs and the Gateway Review Process can be found in Appendix 2.

The Trust uses WAVE (programme management software) as the primary tool for all Turnaround project plans. Where possible, projects are expected to have a neutral or positive impact on quality as well as reducing costs or generating income. As a minimum they should not put the Trust at risk by bringing quality below essential standards. This approach aligns with the Trust's Risk Management Strategy, which details how the Trust identifies, manages and reduces risk across the organisation. Project Managers are required to assess the project against each of the risk areas covered in the QIA, assigning a risk score and detailing mitigating actions.

Under the AOF, all QIAs are examined and approved as part of each Hospital/MCS own Gateway Review process. Following which a desktop review will then be carried out at a Group level by the Chief Nurse, Joint Medical Director, Chief Operating Officer and Human Resources Director. The purpose being to review hospital scoring and documentation of mitigating actions to reduce the impact risk.

All project plans must include a range of Key Performance Indicators (KPIs), both financial and non-financial, that link to the quality of services or patient experience. These indicators inform a QIA to determine whether the project can go ahead based on the risk posed.

The executive team, led by the Group Chief Nurse and Group Joint Medical Directors, provide oversight to the QIA process. Hospital/MCS Medical Directors and Directors of Nursing review and monitor the progress of projects to ensure that the standards of quality and patient experience are maintained.

Triangulation of Quality with Workforce and Finance

The Trust utilises indicators extensively to inform and monitor the quality agenda. Data is used to triangulate quality, workforce and financial indicators, which are monitored by the Board of Directors.

The key indicators used in this process are set out in Appendix 3.

3. Workforce Planning

Workforce Strategy

Following integration of our legacy Trusts, our Workforce Strategy has been developed which outlines the vision and strategy, identifying our future workforce requirements. The strategy takes into account the known and anticipated challenges and opportunities that impact on us. These include:

- Planning and developing our workforce for the future by better connecting new service models and ways of working e.g. service strategies, standardised operating models, financial planning with workforce plans
- Capitalising on the value of a diverse and developing health and social system that interfaces with other sectors such as industry and academia
- Embedding the Group model, provider collaboration and integration and investing in digital and transformation capabilities
- Further developing and meeting the needs of a diverse workforce, reflective of our community through e.g. effective talent management and widening participation
- Attracting and recruiting new staff and retaining current staff to ensure improved and sustainable skill mix and minimising vacancies
- Supporting a richer skill mix and developing effective multi-disciplinary teams through development of new roles and new routes for progression e.g. apprenticeships
- Developing flexible employment offers, fair access to CPD and learning and education opportunities
- Developing a compassionate and inclusive leadership culture that embeds our values, improves working conditions, enables flexible working patterns and positive health and wellbeing
- Reducing agency spend and sickness and ensuring cost effective utilisation of permanent and temporary staffing
- Addressing and sustaining workforce productivity and performance
- Enabling a flexible and adaptable workforce able to work across professional groups, services and organisational boundaries

Workforce Planning

Our high level workforce requirements are estimated through the development of the Trust Workforce Plan that is submitted to Health Education England. This forms the overarching framework within which Hospitals/MCS HR & OD Directors work with the wider Hospital/MCS leadership and HR and OD teams, clinicians and managers within to develop their local workforce plans. Local workforce plans are developed as part of the business planning process and integrated with both financial, quality and activity plans to ensure that they are affordable and sustainable. The local workforce plans are reviewed and signed off at Hospital/MCS level and then formally signed off at Group Executive Director-level to ensure that there is sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services.

Workforce Challenges

Description of Workforce challenges	**Impact on Workforce**	**Initiatives in place**
National shortages in some professions, e.g. Consultants in Radiology, Dermatology Ophthalmology, ED, Acute Medicine, junior medics (all levels), Paediatric, Haematology, Medical, Oncology, Staff Nurses, Orthopaedic Adult & Paediatric middle grades, AHPs, Midwives, Pharmacists, Biomedical Scientists.	Not enough people are training in some specialty areas so the supply is limited. Difficulty in recruiting to establishment; difficulty in rostering; reliance on bank and agency; impact on engagement and morale.	Fewer people are going through training routes so our focus is to make Trust Grade medical positions more attractive to recruit and retain. We are offering masters-level courses and exploring the development of our own masters-level programme as a USP of our attraction strategy. We are offering more flexibility to our doctors to aid retention e.g.: F3 grades/Clinical Fellows rotational posts and career breaks for travelling opportunities. Introduction of medical e-Rostering and activity management software. Recruitment plans in place to address vacancies. Recruitment team working on reducing time to hire. Roll out of NHS Professionals to the rest of the Trust. Temporary Staffing Assurance Board provides oversight and governance.
Retention in shortage occupation groups.	Difficulty in maintaining establishment; difficulty in rostering; reliance on bank and agency; impact on engagement and morale.	Leadership and culture strategy and Hospital/MCS retention/engagement plans in place. Review of staff survey/pulse questionnaire results to address areas impacting upon retention. “What Matters to Me Programme”. Extended Nursing and Midwifery induction for new starters. Introduction of 12-hour shifts for staff wishing to condense their hours over a shorter week. Band 5 rotation programmes for newly qualified staff.
Sickness absence not consistently below Trust target of 3.6% across the Trust.	Reduced workforce availability to deliver services causing pressure for colleagues; impact on engagement and morale; reliance on bank and agency to fill gaps.	All Hospitals/MCS have sickness absence improvement plans in place. A new Employee Health and Wellbeing model is in development and Employee Assistance Programme in place. Absence Manager system in place at Wythenshawe, and will be rolled out at ORC. Targeting of identified hot spot areas with facilitated support and actions.

Temporary staffing use high	Inconsistent workforce in wards and departments; impact on engagement and sickness absence.	Continued scrutiny by Hospital/MCS Leadership Teams. Temporary Staffing Assurance Board in place. Use of TempRE internal bank system. NHS Professionals in place as the long-term partner supplying nurses and midwives. Allocate e-rostering in place and introducing at Wythenshawe. Harmonised rates of pay for medical staff, particularly junior and middle-grade doctors. Roll out of locum booking e-form to ORC. AHP moving to NHSP and ongoing close monitoring of agency expenditure realising a reduction month on month of agency costs. Discussions with procurement and agencies to realise a reduction in booking rates and commission rates is ongoing.
Requirement to increase the experience and representation of BME staff.	Impact on recruitment and retention linked to poor staff experience	In 2019 MFT will be launching a programme of work aimed at ensuring that BME staff have the opportunity and organisational support to progress. MFT is reviewing is attraction and talent management programmes to build in diverse panels, diverse talent pools, working with recruiters to ensure outreach to all parts of the community. The work will be tracked via the AOD BME performance measures at both Group and Hospital level.

Workforce Risks

Description of Workforce Risk	**Impact on Risk (H,M,L)**	**Risk response strategy**	**Timescales and progress to date**
Band 5 Nursing & Band 5 & 6 Midwifery vacancies: At December 2018, there were 740.7 wte (10.2%) qualified nursing and midwifery vacancies Trust-wide. Of these 554.5 wte are band 5 nurses and band 5 & 6	High	Long standing escalation plans in place to manage staffing shortages. Trust-wide recruitment campaigns to attract both experienced and newly qualified nurses and midwives. Recruit domestic and international nurse and midwives through 'Proud to Care' recruitment campaign. Regular nurse recruitment events at Corporate level and in Hospitals/MCSs.	Circa 188 nurses and midwives with conditional job offers and due to start before February 2019. Open days at WTWA and ORC attracted over 200 delegates. WTWA and MRI planning local recruitment events to support recruitment into specialty areas. MFT also has a presence at national recruitment events and HEI open days (within Manchester and across the North West). Three cohorts of Trainee Nurse Associates (221 in total) in training.

midwives, equating to a vacancy rate of 13.9% for this group.		Employ Trainee Nurse Associates.	The first cohort of 81 will qualify in February 2019. All have been appointed and given a conditional offer of employment.
Medical Vacancies: Difficulty filling posts at Consultant level in Acute Medicine, Dermatology, Emergency Medicine, Paediatric dentistry, sub-specialties in Radiology and Ophthalmology. Also junior role in Acute Medicine, Surgical and General Medicine Specialties and Paediatrics.	High	Targeted recruitment campaigns (both domestic and international) for key posts and specialties. Working with TMP (advertising agency) on a recruitment campaign for hard to fill Consultant vacancies across North, Central and South Manchester.	Successful in application to become a sponsoring body for international medical graduates (IMGs).Can now employ IMGs on a Tier 5 visa – will assist difficulties in filling vacancies. Recently recruited four consultant medical staff in ED. Medicine (MRI) has undertaken a successful international recruitment campaign and appointed a number of Clinical Fellows. Working with North Manchester and successfully recruited a number of Consultants in Obstetrics and Gynaecology. Leading role in the development and employment of Physicians Associates. Working with Deanery in relation to trainees and initiatives to offer employment places before qualified.
AHPs & Healthcare Scientists Vacancies	High	Developed new roles based on skill mix, and continue to 'grow our own' through our internal training programmes in shortage professional roles. Working with recruitment and TMP on focussed recruitment campaigns.	Lab Medicine – Planning work has commenced to transition to a GM Pathology approach. Pharmacy – Opportunities from Trust integration being explored to use staff more effectively. Pharmacy Technicians being increasingly used to help ease workforce pressures. Held an open day for Lab Medicine – over 100 potential applicants signed up. Laboratory Medicine – Undertook deep dive workforce review to fully understand workforce issues and develop action plan.
Band 5 Staff Nurse turnover is at	High	Hospital/MCSs all have local retention plans,	Hospitals/MCSs maintain focus on staff wellbeing and introduced schemes

12.8% for December 2018		underpinned with staff engagement work, to understand and act on the reasons nurses leave.	e.g. staff appreciation schemes, What Matters to Me, take a break, 12 hour shifts, and rehydration stations. Retention summit held to consider further ideas to retain staff.
International Nurse Recruitment: 40% of international recruits lost after conditional offer (made overseas) and do not progress through the recruitment process. Reasons include failure to progress past IELTs stage.	High	Work closely with NMC providing feedback and consult on changes to the IR process. Work with international recruitment partner agency to improve local selection and support candidates undertaking IELTs/OET through IELTs school. Undertake monthly Skype interviews with applicants who have achieved the required level IELTS/OET.	Work with NMC has led to the introduction of OET testing. (Found to improve English testing pass rates). Currently a Beta 2 Pilot Site working with the Home Office to allow staff from Europe to fast-track applications for British citizenship. Brexit contingency planning progressing, monitoring of turnover, proactive communication and engagement with our European staff.
Trust Sickness Absence Policy – different policies with different triggers	High	Policy Development Assurance Group reviewing policies in order of priority. Sickness absence is a key priority. AD of Workforce Governance and Quality accountable for alignment and monitoring.	Sickness absence policy has been drafted and is currently with stakeholders for comment and review. Estimated date of completion is March 2019.
Sickness absence run rate is 4.8% (above internal target of 3.6%)	High	Hospitals and MCSs tackle sickness absence locally, and use data/reports from e-Wip to support action. Trust invested in software to improve rostering and sickness absence including specific absence product – Absence Manager.	Trajectories and plans agreed for Hospital/MCSs to meet target by 31/03/19. Health and Wellbeing Strategy developed. E-Rostering used by nurses and midwives, giving visibility of absence and triggers warnings for action. Medics' Rostering introduced at Wythenshawe and being rolled out at ORC. Absence Manager software at Wythenshawe being rolled out at ORC. Sickness Reports at a Trust and granular level and heat maps identify high absence areas.

Medical Staffing Sickness Absence		Introduction of Medics' rostering Trust-wide will lead to greater visibility of sickness absence and mechanisms to flag absence that has triggered against Policy.	Hospital/MCSs agreed trajectories to meet target by 31/03/19 and plans in place to address. Health and Wellbeing Strategy developed. Medics' Rostering introduced at Wythenshawe and being rolled out at ORC. Absence Manager software at Wythenshawe being rolled out at ORC. E-Wip provides Sickness Reports at a Trust-wide and granular level and heat maps identify areas with high absence.
Local workforce challenge due to post-merger pressures capacity to progress transformation whilst delivering BAU in the context of staff resilience, vacancies, sickness absence and barriers e.g. ts and cs, professional protectionism.	High	Development of Leadership and culture strategy; development of Employee Health and Wellbeing model to provide increased, proactive support to staff and teams.	Targeting areas most affected, utilising staff survey information, workforce information heat map data, development and delivery of initiatives aligned to the leadership and culture strategy. Providing support and increased monitoring to these areas to maintain and increase staff resilience.
Recruitment to senior leadership, clinical and executive posts due to the Executive pay framework and pension tax penalties	High	Director of Workforce and OD part of national group to influence and keep organisation appraised of developments. Financial advice for staff to be offered to inform and signpost. Review flexible workforce/retirement policy to explore options to attract and retain highly skilled and knowledgeable workers.	

Long term vacancies

Description of long term vacancy, including the time this has been a vacancy post	WTE impact	Impact on Service delivery	Initiatives in place, along with timescales
Clinical Support Services (CSS)			
Band 5/6 radiographers Multiple posts across MFT. Continuing churn.	Circa 20 to 25 at any one time	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	UK recruitment campaign using social media and open days. Leading GM international recruitment campaign Feb/March 2019. Development of a specific retention strategy supporting education and rotation. National shortage occupation.
Band 6 BMS. Continuing churn in these posts.	Circa 5 at any one time	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	Over recruitment plan nearing completion. Leading GM development of career structure from level 2 through to level 6 for BMS staff making use of apprenticeships commencing Feb 2019. National shortage occupation.
Consultant Radiologists	Circa 3	Patient Safety, Patient Experience, Operational delivery	Exploring international recruitment. Enhanced roles for radiographers/MSC level. Meeting with trainees coming up to CCT to understand what they are looking for. National shortage occupation.
Band 6 and 7 pharmacists	Circa 20	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	Successful December/January campaign to make early offers to newly qualified post registration pharmacists. Keeping warm campaign until summer 2019 starts. Working patterns to compete with private and primary care offer.
Band 5/6 radiographers Multiple posts across MFT. Continuing churn.	Circa 20 to 25 at any one time	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	UK recruitment campaign using social media and open days. Leading GM international recruitment campaign Feb/March 2019. Development of a specific retention strategy supporting education and rotation. National shortage occupation
Royal Manchester Children's Hospital			
Consultant Psychiatrists	2.1WTE	Patient Safety, Patient Experience, Operational Delivery,	Use of High Costs agency to support service delivery has reduced. Talent spotting ST6+ grades and offering enhanced training to develop future consultant pipeline over the next

		Staff resilience and wellbeing	12m. This is a significant national shortage occupation.
Haematology/Oncology Fellows	2.0 WTE	Patient Safety, Patient Experience	Full review of job description and recruitment processes undertaken to streamline and offer enhanced educational opportunities to international junior doctors. New CF posts should be in post within 3m.
Wythenshawe, Altrincham, Trafford and Withington (WTWA)			
Band 2 Health Care Support Workers. There are multiple posts across the hospital sites in medical and surgical areas.	97.6 WTE based on December 2018 staff in post	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	As per nursing and midwifery section below.
Consultant Dermatologists		Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	Use of High Costs agency to support service delivery has reduced. Active recruitment to vacancies – one offer has been made and pre-employment checks are in progress. This is a significant national shortage occupation.
Manchester Royal Infirmary			
MRI - M9 Higher numbers of Leavers in AMU. Higher levels of vacancies in Respiratory, Orthopaedics, AMU & Renal Nursing Assistants band 2	104wte	Patient Experience, Operational Delivery, Staff resilience and wellbeing, Increase use of agency, bank & overtime	**Workforce plan** developed M10 *Including re-designed roles e.g. Therapy Coordinators, Pharmacy Technicians, and flexible working e.g. school hrs* **Retention Plan Q4** *e.g. career pathways, retire & return.* **Recruitment event** for Nursing Assistants 22/2
Consultants in Acute Integrated Medicine (AIM) Emergency Dept. Care of the Elderly/Frailty services		Patient Experience, Operational Delivery, Staff resilience and wellbeing, Use of agency & locums	**Workforce Plan** Replacing gaps by increasing ANP's & Nurse Consultants **ANPs:** AIM - 2 x 19/20 & 2 x 20/21, ED - 4 x 19/20 & 4 x 20/21 **Nurse Consultants:** AIM - 1 x 19/20 & 1 x 20/21, ED - 2 x 19/20 & 1 x 20/21 Care of the Elderly/Frailty. Cross site working/rotation 19/20

Junior Doctor and Middle Rota Gaps – Trust-wide			
Junior Doctor and Middle Rota Gaps	Various	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	**St Mary's:** Consideration of Physician Associates to fill gap supporting a review of different ways of working across all staff groups. Developing post graduate programme with MMU as part of an enhanced offer to Trust doctor roles. **MRI:** Medical Workforce Group & Organisational Turnaround Group Review of medical expenditure, gaps and agency use. New Ways of Working - 9 Physicians Associates 19/20 **WTWA:** Review of gaps and agency use through the WTWA medical productivity group. Assessment of Deanery gaps over previous two years and backfilling through permanent and fixed term appointments offering flexibility to post holders where possible. Supporting further study e.g. Master programmes within Trauma and Orthopaedics. **RMCH:** New rotas that offer joint working across department and enhanced education opportunities will be implemented from 6th March. This is likely to make RMCH a more attractive hospital to Junior Doctors, enhancing our rota fill rates. Focus on developing international recruitment using enhanced job descriptions that offer training and education over the next 3 months. Potential to support funded fellowships during the next 12 months.
Band 5/6 Nurses, Midwives etc. – Trust wide			
Multiple posts across the Hospitals/MCSs. Band 5/6 Registered Midwives, neonatal nurses and theatre nurses Reliant on newly qualified nurses to fill gaps so vacancy	WTWA: 168.2 WTE based on December 2018 staff in post MRI: 12.7% qualified nursing	Patient Safety, Patient Experience, Operational Delivery, Staff resilience and wellbeing	**WTWA**: Recruitment events are ongoing throughout the year. Talent spotting Nursing Students and offering posts prior to graduation. Launch of a specific nursing recruitment and retention strategy in February which includes including establishing a Matron post focussing on pastoral support and preceptorship offer for newly

levels fluctuate throughout the year but peak through the summer months prior to new starters from September onwards	vacancies. 18.9% (of the above) vacant band 5 posts.		qualified nurses as well as identifying sustainable methods of retention through wellbeing, education and research opportunities. Use of Practice Based Educators and refocus of coverage to include urgent care. **St Mary's:** Regular recruitment open days and close links with University for recruitment of students. Engagement events with student nurses to create a relationship with the Trust at an early stage. Enhanced attraction and retention plan to maximise the offer that is made to candidates to work within SMH. Preceptorship for midwives. Promotion of work life balance and working environment through Caring for You and what Matters to Me programmes of work. Participation in Trust's international recruitment programme. **MRI:** Rotation in Emergency Care. Daily Staffing Review - Senior nurses to ensure safe staffing. MRI Nursing Workforce Group & Organisational Turnaround Group Review of nursing expenditure, gaps, agency use. **RMCH:** Quarterly recruitment open days planned throughout the year. Talent spotting Nursing Students and offering posts prior to graduation. Development of a specific nursing recruitment and retention strategy within 3m, enhancing the pastoral support and preceptorship offer for newly qualified nurses as well as identifying sustainable methods of retention through wellbeing, education and research opportunities.

4. Activity and Financial Planning

1. Financial forecasts and modelling

2019/20 Financial Plan

The Trust is required to deliver within at worst a net deficit of £13m on a control total basis for 2019/20. Provided that the Trust achieves this result or better, then we remain eligible for national Provider Sustainability and linked funding of £27m. Achievement of this further national funding is therefore factored into the plan resulting in a planned surplus of £14m for 2019/20.

Financial Forecast and Modelling

Run Rate and Financial Pressures

The Trust's financial plan for 2019/20 continues to require full delivery of the control total. This financial plan is built from the underlying run rate performance over 2018/19, tested against months 7 to 10 in particular.

Run Rate challenges

The elements impacting on the run rate challenges are:

- The accumulated scale of efficiency requirements over recent years, for which Hospitals have not been able to fully identify sufficient delivery plans
- The excess costs of agency and locum cover in medical, nursing and other staff groups
- Overspending on clinical consumables and other non-pay costs

These factors, across Hospitals' operating financial performance in 2018/19, result in underlying run rate deficits which amount to over £40m when annualised.

2019/20 efficiency and funding challenges: £20m

The efficiency and funding reduction challenges comprise the below elements:

i. Pay settlements: £25m is the second year cost increase resulting from the 3 year pay agreement across all 'Agenda for Change' staff groups. £8m is the forecast cost increase for medical staffing, including the full year effect of the 2018/19 pay settlement and an estimate at 2% for 2019/20.

ii. Prescribing and clinical consumables costs are forecast to increase by £5m and premises costs by £4m, with CNST premium reducing by £2m.

iii. £3m of other cost increases include an increased distribution of Clinical Excellence Awards and Apprenticeship Levy Costs.

iv. PFI operating costs and premises costs are forecast to increase by £2m.

v. These cost increases are offset in 2019/20 by £25m of price increases provided through the updated national NHS financial framework.

The combined run-rate and efficiency challenge for 2018/19 therefore means that delivery plans of £60m are required, to secure a net deficit at worst before PSF of £13m.

Activity and Contract Income assumptions/approach

The 2019/20 activity plan has been developed using the Trust's activity planning model which is deployed at hospital level.

For both planned and unscheduled care the model was underpinned by forecast activity from months 1-7 of 2018/19, then reviewed and adjusted for the following factors, where relevant: waiting list movements; assessment of opportunity to improve against performance standards e.g. RTT at specialty level and diagnostic waiting times, and underlying population and demographic trends.

All income workings reflect the December (Planning) prices released by NHSI and are inclusive of the net uplift and CQUIN /PSF transfer into prices with the corresponding reductions in the latter income streams. MRET income of £3.7m is included in the overall income figures. The underlying approach to contract planning is compliant with the NHS Operational Planning and Contracting Guidance for 2019/20.

The activity and expected associated income have been shared with Commissioners to inform contract negotiations.

The 2019/20 plan reflects £2.4m of income to fund Healthier Together Transition costs, along with Transformation Funding to support the Single Hospital Services Programme.

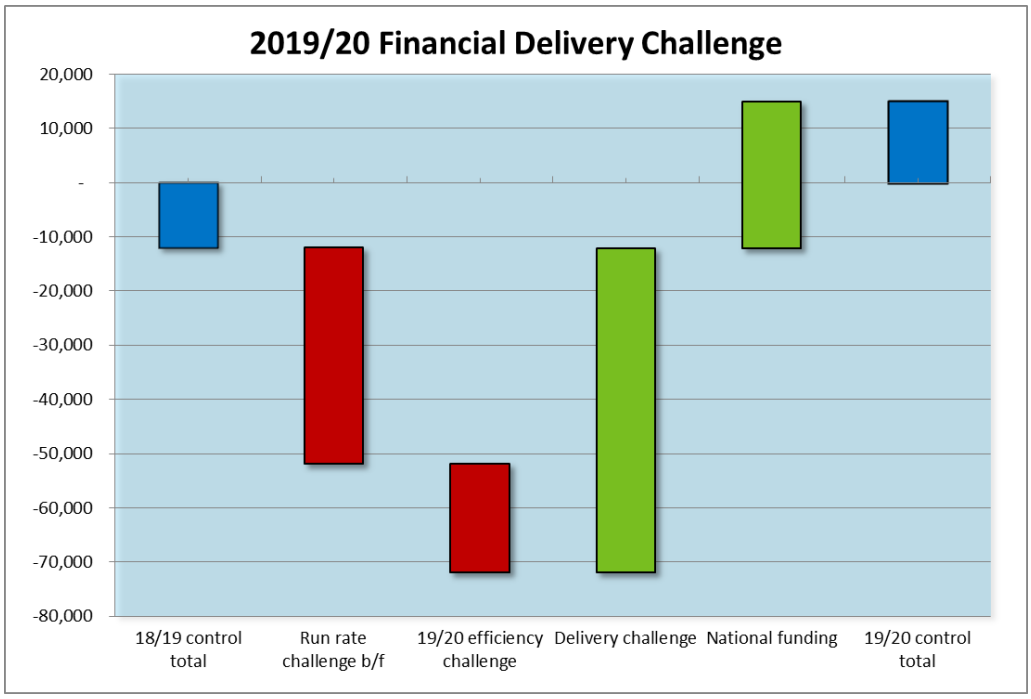
Exclusions

The impact of the potential North Manchester merger and the incorporation of Trafford Community Services have been excluded from the plan at this stage.

2. Efficiency savings for 2019/20

MFT 2019/20 Financial Delivery challenge

The aggregate financial delivery challenge for 2019/20 is £60m combining the underlying £40m run rate operating deficit and the £20m new efficiency challenge from which delivery plans return the position to a net deficit of £13m before PSF and MRET.



Solutions continue to be identified across Hospitals to address the financial challenge, and include:

- £3.1m of full year effect from continuing delivery which began mid-year in 2018/19
- cost reductions which include further progress with to reducing the use of agency staffing to support delivery of the 2019/20 agency ceiling.
- new delivery for 2019/20, including margin from recovery and growth in clinical income

Hospitals have developed the required delivery programmes for the additional productivity delivery and cost savings required in 2019/20. These are being moved into full implementation ahead of the new financial year starting in April.
This work has been supported by the development of opportunity packs incorporating the principles of GIRFT and Model Hospital benchmarking. The Trust is also participating in the GM wide efficiency programmes. The Trust continues to evolve and develop its approach to strategic procurement and clinical productivity gains as key strands in delivering the required efficiency savings together with embedding and developing further efficiencies arising from the merger. Hospitals are supported with delivery as required, from a full Turnaround team and PMO infrastructure to assist with driving delivery progress week-by-week.

The Quality Impact assessment process is overseen at Board level by the Joint Medical Directors and Chief Nurse with the support of other Group Executives including COO and the Executive Director of Workforce and OD. In the first instance Hospitals undertake a local QIA process. These are then reviewed through a Group QIA sign-off process which includes both a desk top review and, as required, face to face check and challenge sessions with Hospital leadership teams to examine delivery risks and mitigations more closely where any potential concerns are identified.

Risks to the Financial Plan

The detail from Hospitals' delivery plans identifies how each Hospital will bridge the financial delivery challenge, maintaining commitment to delivery of the control total set for the Trust – and in turn maintaining access to the further conditional £27m of national Provider Sustainability funding.

Financial performance and achievement of these delivery programmes will be monitored on a regular basis at Hospital Board level, through the Trust's Accountability & Oversight Framework and at the Board Finance Scrutiny Committee (FSC). FSC will continue to oversee and scrutinise the achievement of the overall Financial Plan and to receive assurances on the progress with delivery programmes across Hospitals. Delivery risks will be reported and reviewed at this Committee.

Resultant income and expenditure plan

This plan for 2019/20 underpins acceptance of the requirements set out in the Control Total letter to MFT of 15th January 2019 and achieving a control total position of a net deficit at worst of £13m. £27m of further national Provider Sustainability funding has accordingly been incorporated as income within MFT's financial plans and cash flow forecasts.

The high level Income & Expenditure Account for forecast outturn 2018/19 and the financial plan for 2019/20 is set out below.

	2018/19 Forecast £m	2019/20 Plan £m
Income		
Operating income	1,430	1,503
Other income	227	239
Total income	**1,657**	**1,742**
Expenditure		
Pay	-949	-1,007
Non pay	-618	-651
Total expenditure	**-1,567**	**-1,658**
EBITDA	**90**	**84**
Interest, dividend & depreciation	**-70**	**-70**
Net position on control total basis	**19**	**14**
Financial Risk Rating	**2**	**2**

Internal consistency between financial, workforce and activity plans has been tested through the use of the triangulation tools and the existing modelling which is initiated from actual financial and workforce data from recent months and incorporates required changes from that baseline. The activity plans are priced and valued and those figures are incorporated into the financial plan together with the costs of delivery.

3. Agency rules

The Plan sets out the Trust's aim to reduce agency spend, building on progress already made in 2018/19, detailed below. Planned spend for 2019/20 is 10% less than MFT's Agency Ceiling in 2019/20.

	Average months 1-6	Average months 7-9	Month 10
	£k	£k	£k
Agency Spend 2018/19	-2,786	-2,424	-1,609

4. Capital Planning

Following rigorous review of the capital schemes, the indicative capital programme for 2019/20 is shown at a total value of £66m related to the following areas;

Scheme Descriptions	Total 19/20 £m
Cardiac MR Scanner (Charity Funded)	3
Diabetes Centre (Charity Fund)	2
Helipad (Charity Funded)	5
Other Charity Schemes	1
MRI Emergency Department - Project RED	4
RMCH Emergency Department - Project PAED	1
PFI Lifecycle	10
Estates Schemes	31
Total Estate Schemes	56
IM&T Schemes	14
Equipment Schemes	5
Total Capital Programme	**75**
Forecast potential slippage anticipated in 19/20	(9)
Total Capital Programme 2019/20	**66**

Capital expenditure plans have been prioritised, with several iterations of scrutinising the proposed capital plan by both the Estates Team and IM&T Teams, along with the Group and the hospitals. This has included a review of all the schemes, including the pre-commitment being carried forward from 2018/19, totaling £19m and the PFI Lifecycle cost of £10m. Consideration has also been given to future year's capital programme of the impact from any schemes which will be progressed in 2019/20.

The final draft Capital Programme in the 2019/20 plan is to support delivery of the objectives of the Trust.

Key schemes include:

- Various schemes totaling £10.2m are being funding by the Trust Charity and other Charities including the Cardiac MR Scanner at the Wythenshawe Hospital site, the Diabetes Centre and the Helipad, both located at the Oxford Road Campus.
- Continued investment in the schemes to redevelop, expand and refurbish the Emergency Department and the Children's Emergency Department based on the Oxford Road Campus. The total value included in the programme for these two projects is £5m. This will provide increased capacity and improve patient flow, thereby supporting the key strategic objective of safe, effective and timely care for patients.
- Funding for a rolling programme to address backlog maintenance, including the continuation of schemes relating the Health and Safety, along with Fire Stopping works.
- Included in the IM&T schemes is £2.5m relating to the procurement of, and preparatory work for, a Trust-wide Electronic Patients Record (EPR) system and continuing tactical short-term investments in current systems to provide the following benefits:
    - Clinical benefits – improving services to patients, increasing the reliability, safety and consistency of care, and promoting evidence-based practice;
    - Operational benefits – increasing the efficiency of patient flows and utilisation of resources, improving the user interface, reducing duplication and barriers to use, and supporting new Trust clinical pathways.

- Funding for the ongoing medical equipment replacement programme which is prioritised using a risk-based approach, with a commitment to rolling replacement programmes.

The Trust's capital investment programme is budgeted at £75m including £10m of charitable donations. Internally generated cash of £56m is available therefore the programme is relying on slippage of £9m in 2019/20. This underlines the critical importance of an improvement in the underlying financial performance to provide an improved liquidity position to enable a further review of the capital schemes that were not prioritised in the above programme.

The uncertainty over any access to external financing facilities in 2019/20 has placed additional pressure on the capital programme. However, following a review a decision has been made to fund the high priority schemes beyond the internally generated funds in-year giving the capital investment required to progress the Trust's key objectives during 2018/19.

To give the Trust additional control over the pressure of the additional internally generated funds, following a further review and from the historic knowledge of the Capital Programme the Trust is anticipating an element of slippage of £9m, which provides a total capital programme of £66m.

2019/20 NHSI Financial Plan Risk Rating

The resultant quarter by quarter risk ratings are shown in the table below:

	2018/19	2019/20	2019/20	2019/20	2019/20	2019/20
	Forecast	Q1	Q2	Q3	Q4	Year Ending
Capital service cover rating	3	4	4	3	3	3
Liquidity rating	2	2	2	2	3	3
I&E margin rating	1	3	2	2	2	2
Variance From Control Total rating	1	1	1	1	1	1
Agency rating	2	1	1	1	1	1
Plan risk rating after overrides	2	3	3	2	2	2

5. Link to the Local Sustainability and Transformation Plan

MFT is committed to working in partnership with colleagues across health and social care to achieve our ambition of delivering the 'greatest and fastest possible improvement to the health and wellbeing of the 2.8 million residents of GM'. The 2015 GM Health and Social Care Partnership (GMHSCP) Sustainability and Transformation Plan 'Taking Charge' set out how public services would be radically reformed through five transformation themes, which would help us to achieve a clinically and financially sustainable health and social care system.

2019/20 will be a critical delivery year for Greater Manchester as: the fourth year of delivery of our *Taking Charge* strategy; our first annual plan developed in the context of the new Greater Manchester Health and Social Care Prospectus; and the first since publication of the NHS Long Term Plan. This is also in the wider context of the launch of a number of key strategies that signal the next phase in the GM's journey as a devolved city region, including: the Public Services White Paper, the Local Industrial Strategy and the GM Spatial Framework.

The Greater Manchester Health and Social Care Prospectus updates the story of Greater Manchester's health and social care devolution journey – as set out in *Taking Charge*. The Prospectus has been developed in the context of the integration of NHS England and NHS Improvement. It sets out our long-term health and social care strategy for Greater Manchester – which will meet, and go beyond, the ambition in the Long Term Plan.

The Prospectus positions Greater Manchester as a comprehensive population health system – pushing beyond the boundaries of Integrated Care Systems. It also signals the opportunity for Greater Manchester to act as an accelerator site for scaled implementation of initiatives in the Long Term Plan. This would, for example, build on the system-wide structures we already have in place for: digital; urgent and emergency care transformation; personalisation; and health innovation.

2019/20 will see us make further progress on the key building blocks of the GM system:

- A Local Care Organisation (LCO) in each of Greater Manchester's 10 localities will integrate provision based on neighbourhood models focussed on improving the health and wellbeing of populations of 30-50,000 and are structured around GP-registered lists and 'place-based' working. The LCOs will form part of a much broader model of local service delivery focused on a new relationship with citizens and asset based approaches, with very strong focus on the voluntary, community and social enterprise (VCSE) sector.
- Pooled health and social care resources are managed through an integrated single commissioning function in all 10 localities, offering a deep understanding of their interdependence and how investment in high-quality social care underpins the stability of both demand and finance in the NHS.
- New models of provision mean Greater Manchester hospitals work together at a much greater scale than ever before to consistent quality standards.

- A Greater Manchester-wide architecture operates across the city-region where this makes sense, such as a commissioning hub, digital and workforce collaborative, and a 'one public service estate' strategy.

We will continue the strong progress we are making in a number of delivery areas including mental health, smoking cessation, primary care access and quality, reducing delayed discharges and improving standards in care homes and domiciliary care. This is underpinned by the strong financial management that has seen us deliver surpluses since we achieved devolved status.

The following describes how MFT is taking forward the Greater Manchester transformation themes.

Theme 1 We are working with partners on prevention services e.g. the Wythenshawe respiratory team pioneered the CURE initiative within the UK as well as the development of lung health checks.

Theme 2 We work in partnership with the other organisations in the Manchester health and social care system; this is led at the highest level through the Manchester Health and Wellbeing Board. We also work as part of the Trafford health and social care system.

Theme 3 projects	**Provider Transformation Lead**	**Model of care development**	**Clinical Reference Group approval**	**Theme 3 Executive and Board approval**	**Modelling complete**	**Implementation**	**Current status**
Vascular	MFT	✓	✓	✓	✓		Site specific decisions in progress
Breast cancer	MFT	✓	✓	✓	✓		
Paediatric Surgery	MFT	✓	✓	✓	✓		
Cardiology	MFT & Wigan	✓	✓	✓	✓		
Benign Urology	Stockport	✓	✓	✓	✓		
Neuro-rehab	Salford Royal	✓	✓	✓	✓		
Ortho & MSK	WWL	✓	✓	✓	✓		
Respiratory	MFT	✓					
Critical Care	MFT & ODN	✓					
Paediatric Medicine	MFT						Scoping stage
Urology cancer	Transformation stage	✓	✓	✓	✓	✓	Launching 2019/2020
Gynaecology cancer		✓	✓	✓	✓	✓	
OG cancer		✓	✓	✓	✓	✓	Launched September 2018
Healthier Together		✓	N/A	N/A	✓		

Theme 4

- MFT designated one of two Pathology hubs in GM
- Leading work on GM pathology workforce
- Co-chair of the GM PACS procurement board
- Leading the development and roll out of the Haematological Cancers Diagnostic Partnership across GM

Manchester Local Care Organisation

- Established in April 2018 in partnership with Manchester Health and Care Commissioning, Manchester City Council, Manchester Primary Care Partnership and Greater Manchester Mental Health NHS Foundation Trust
- Delivery of out-of-hospital care and improved community-based health services aimed at preventing illness and caring for people closer to home.

Single Hospital Service

- The Post Transaction Integration Plan (PTIP) was developed prior to the establishment of MFT and sets out how the integration of the two legacy Trusts would be planned and delivered.
- The PTIP has been updated through four iterations as the merger and integration process has progressed. Significant integration activity continues across the Trust. This will be maintained and intensified during 2019/20, particularly as the new MFT service strategy is implemented.
- The majority of merger integration activity is now being delivered as 'business as usual' with relevant Group Executive Directors leading the integration activity relevant to their portfolios. Work is overseen by an Integration Steering Group (ISG), supported by an Integration Management Office. The ISG provides an escalation route for integration issues that cannot be resolved within the Trust's formal governance arrangements.
- The delivery of integration is supported by funding from the Greater Manchester Transformation Fund. The allocation, and use of this funding, is closely monitored to ensure that the funds effectively support integration. Oversight of the funding is provided by the ISG and monitored by Greater Manchester Health and Social Care Partnership.

6. Membership and Elections

The majority of our Governors are elected from and by our members with all qualifying members that are aged 16 years or over being able to nominate themselves to stand for election as a Governor. All qualifying members are issued with ballot papers and vote for the candidate(s) that they wish to be elected to sit on the MFT Council of Governors. During 2018, 3 Governor seats (Public) were open for election with 17 valid candidates standing for election. During 2019, 9 seats (Public & Staff) will be open for election.

At the start of the process a Chairman invitation letter is sent out to all qualifying members along with personalised letters for those who have previously expressed an interest in 'standing for election'. Elections are promoted via social media channels, Trust intranet and staff newsletters. Each Hospitals/MCS receive a bespoke 'Governor Election - Candidate Information Pack' to share with their patients/visitors and staff.

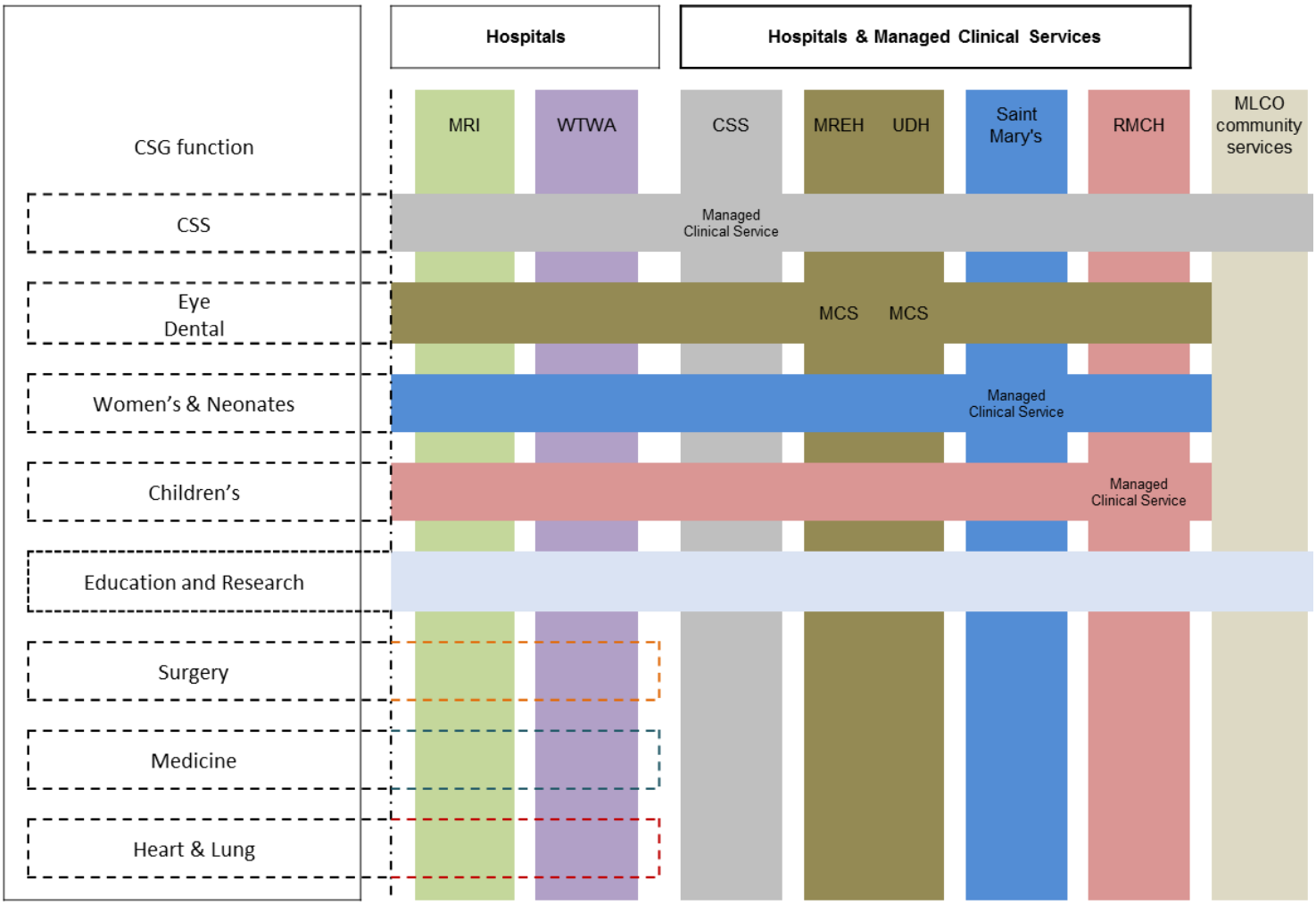
Key Governor training and development activities include:

- Governor Effectiveness and Performance Questionnaire developed with key findings taken forward in Governor Development Sessions in 2018/19 and 2019/20
- Induction Programme for new Governors including an introduction meeting with the Chairman, an overview of the Trust including performance framework, the Single Hospital Service, a tour of the Oxford Road Campus and a Governor Development Event
- Development of a new 'Governor Meeting Framework', to provide further support in relation to their role/key duties with the resultant new meeting structure including Performance Assurance Meetings; Membership & Engagement Sub-Group; Patient Experience Sub-Group and Staff Experience Sub-Group.
- Holding regular Council of Governors' Meetings and Development Sessions where key Risk and Assurance Reports are presented alongside topical health matters from which Governor-driven actions are agreed and taken forward to enhance both Governor development and ultimately patient and staff experiences.
- Bespoke Governor visits for MFT staff to showcase their services and facilities with Governors, providing a forum for Governors to engage with a wide-range of staff.

The Trust's overall membership community is over 44,000 members. Going forward Governors are working with the Trust to enhance Membership engagement initiatives as part of the recently formed Governors' Membership & Engagement Sub-Group. The Trust aims to ensure that public membership is representative of the communities it serves by addressing any natural attrition and membership profile short-falls. This is facilitated each year by holding an annual public member recruitment campaign.

The Governors' Membership & Engagement Sub-Group has been actively involved in developing MFT's Membership and Engagement Strategy alongside public membership recruitment plans/initiatives with a review of the public profile being undertaken (early 2019). A targeted public member recruitment campaign is to be held during February/March 2019 and as part of this campaign, it is anticipated around 2,000 new public members are to be recruited, across targeted profile group namely: young people (11 – 16 and 17 – 21 years) and males in addition to the following Ethnic Groups; White including Gypsy or Irish Traveller and Other, Arab and Chinese.

Appendix 1 MFT Group Structure



Appendix 2 QIA and Gateway Review Process

Approach to Turnaround project planning and quality impact assessment

1. Overview

NHS Improvement's Delivering Sustainable Cost Improvement Programmes Guidance outlines the need for a robust project management approach to support the delivery of cost improvement. This includes project leadership, project planning and project documentation.

- Internal Turnaround, follows this approach, utilising tools and templates prescribed by NHS Improvement. This includes the use of Quality and Equality Impact Assessments to assess the potential effect of a project on clinical quality and safety, clinical outcomes, patient experience, trust reputation and social exclusion.

2. Development of project plans

- For the development and implementation of Turnaround project plans, the Trust uses a five step process, as detailed in the diagram below. This process moves from idea generation, through project planning to delivery.
- Each project requires detail project plans, which include project owner, scope of project, assumptions and interdependencies, financial benefits and KPIs, risk assessment (including QIA) and milestones. The Trust uses WAVE (programme management software) as the primary tool for all Turnaround project plans.
- The Quality Impact Assessments are an important component of this planning process, with each plan containing a detailed QIA, which has been reviewed and approved through a QIA Gateway process.

Diagram: Turnaround planning approach

	Identified	Value assessed/ confirmed	Approved	Implemented	Delivered
	Approval to L1	Approval to L2	Approval to L3	Approval to L4	Approval to L5
Criteria for completion	• Concrete idea developed • **Expected annual savings** roughly quantified	• **Additional analytics** conducted and feasibility confirmed • **Broader implications** from key stakeholders incorporated	• Detailed **implementation plan** developed • **Approved** by required executives and included in budget	• **Idea implemented at scale** • Performance management system operational	• Ideas has **flowed through to the bottom line** • Finance **confirmed savings**
Evidence required	• Description of: – Owner – Primary savings lever – Rough estimates of; Savings, Effort, Timings, Baseline/ addressable spend	• **PID developed** with: – KPIs, – Risks – Mitigations – Timeline	• QIA completed • Completed PID with clear **sign off from key stakeholders and sponsor** • **QIA Gateway**	• **Evidence of implementation**, e.g., contract signed • Savings Acceptance Form signed by Trust	• **Savings validation** by Trust finance
Example	• Idea developed, sized top-down, and presented to Steering Committee	• Costs identified and shared with Steering Committee • Work plan developed for pilot or implementation	• Sponsor approval to proceed with plan • Pilot in progress, or pilot results and implications	• Idea implementation completed in the Trust setting	• Reduction in cost achieved • Performance improvement realized

Approach to Turnaround project planning and quality impact assessment

3. Project Quality Impact Assessment (QIA)

- Where possible, projects are expected to have a neutral or positive impact on quality as well as reducing costs or generating income. As a minimum they should not put the Trust at risk by bringing quality below essential standards.
- The potential risks that transformation, cost saving or income generating projects could have on the quality of services will therefore be assessed as part of the project planning stage, using the Quality Impact Assessment approach defined by the Department of Health.
- This approach aligns with the Trust's Risk Management Strategy, which details how the Trust identifies, manages and reduces risk across the organisation. A component of this is the risk matrix, which details the approach in assessing and mitigating risk across the Trust.
- The Trust has developed an Accountability Oversight Framework (AOF) to support delivery of the organisation's vision and strategic objective. Amongst other matters, the AOF promotes devolved decision making and autonomy subject to regular performance assessments.
- The QIA includes risks relating to a number of key clinical quality, patient experience and operational areas, as detailed in the table, right. This also includes a number of areas relating to equality. Project Managers are required to assess the project against each of these risk areas, assigning a risk score and detailing mitigating actions. Key questions for each of these areas are detailed in the appendix.
- Under the AOF, all QIAs are to examined and approved as part of each Hospital / MCS own Gateway Review process. Following which a desktop review will then be carried out by the Group Chief Nurse, Medical Director, Chief Operating officer and Human Resources Director. The purpose being to review hospital scoring and documentation of mitigating actions to reduce the impact risk.
- A further follow up session with a Hospital may be required if the Group desktop review identifies schemes they believe to be inappropriately scored, not sufficiently mitigated, or which do not sufficiently consider the impact on other hospitals/MCS.

Diagram: Risk Matrix

Severity	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2 :Slight	2 Very Low	4 Very Low	6 low	8 low	10 Medium
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5 Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

Diagram: Quality and Equality Impact Assessment: Risk areas

Corporate Functions
Patient Safety
Clinical Effectiveness
Patient Experience
Operational Effectiveness
Trust Reputation
Equality/Protected Character
Social Exclusion
Other
eQIA: Legislation/Regulation
eQIA: Equality/Protected Characteristics
eQIA: Social Exclusion

Hospital / MCS QIA gateway process - Overview

4. QIA gateway review - overview

- **Purpose:** As part of the Planning Stage, a gateway process is to be used to provide rigorous testing of projects prior to commencement for each Hospital / MCS. This gateway review should cover all projects but will focus on those with a medium to high risk QIA.
- **When it occurs:** This process will occur between February and April, or as required at other points through the financial year.
- **Format and attendees:** At the first stage, Hospital Leadership Teams will undertake their own QIA project reviews to evaluate the QIA ratings and mitigations in their projects. A desktop review will follow undertaken at Group level to review projects submitted and to assess whether a follow up session is required for specific schemes. If a follow up session is required then the following from Hospital leadership teams will be required to present at these review sessions:
  - Director of Nursing
  - Medical Director
  - Director of Finance
  - Director of Operations
  - Director of Human Resources & OD
- **Outcomes:** Outcomes of the Group Level review process
  - All appropriate projects will be reviewed and discussed.
  - Projects that have a low to medium risk QIA, and that have not been selected for review will be deemed approved.
  - Projects that are reviewed and attendees are considered to have provided sufficient assurance of appropriate scoring, sufficient mitigations, or sufficient consideration of the impact on other hospitals/MCS will be deemed approved,
  - Some projects may not be agreed and may require revision and resubmission to the Group Level review process.

Diagram: Hospital Project gateway and approval process

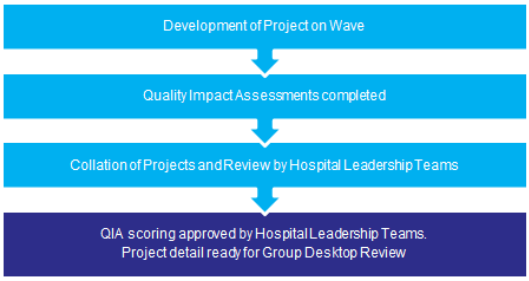
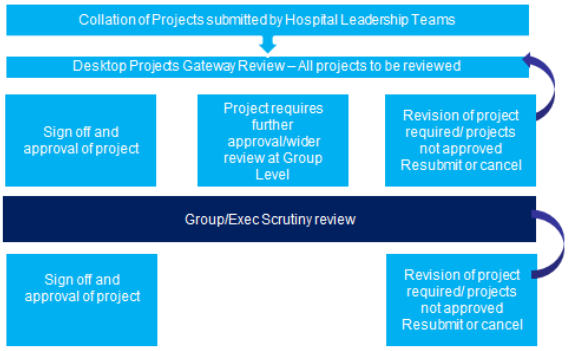


Diagram: Exec Group approval process



5

Hospital/MCS QIA gateway process - Overview

5. Hospital/MCS QIA Gateway Review Meeting – Preparation, Agenda and Follow up

The diagram below sets out the process for the Gateway Review process within Hospitals/MCS and subsequent review at Group Level.

Hospital/MCS Internal Review*

Review of Projects: Hospital/MCS Leadership Team

1. Review projects line by line
2. Review scores assigned to each project and assess the supporting documentation and if necessary request rework of schemes.
3. If required reworked submissions are reviewed before Group Gateway review

****All Cut 3 projects are to be reviewed and scored (including any reworks) by 4th April 2018 to allow submission for initial desktop review by Chief Nurse****

Desktop review to be undertaken by Chief Nurse, Medical Director, COO, HR Director (11th April 2018)

Review of all project QIA:

1. Review projects line by line, focussing on high rated scoring,
2. Assessment of supporting documentation and if necessary request rework of schemes.
3. Desktop review to:
   - Examine presentation of each plan using PID and QIA information.
   - Review Hospital / MCS agreed risk rating, scoring, mitigations planned and any further areas of support required.
   - Agree monitoring required
   - Confirm next steps for circulation – agreement, escalation (to wider Exec Group QIA review), revision or stop
4. If project requires further submission these are to be resubmitted for additional review prior to Group Review **(18th April 2018)**

Group Exec QIA Review by Chief Nurse, Medical Director, COO, HR Director (18th April 2018)

Review of specific project QIA:

1. Review projects by Hospital / MCS which are believed to have not been sufficiently mitigated and/or have an impact on other Hospitals/MCS.
2. Review scores assigned to these escalated projects and assess the supporting documentation. If necessary request rework of schemes.
3. Confirm next steps for these projects. i.e. rework required or agreement to proceed
4. Projects requiring revision will need to be resubmitted to a follow up Review meeting, date to be confirmed.

Appendix 3 Triangulation

Finance Continuity of Services Rating Delivery of Financial Plan – All Divisions Patient Experience Clostridium Difficile - Lapse of Care Complaint Volumes Complaint Volumes - Reopened Complaints - Outstanding Complaints - Outstanding Beyond 40 Days Complaints Resolved Within 25 Days Complaints Unresolved Within 40 Days Compliments FFT % Extremely Likely FFT A&E % Extremely Likely FFT A&E Response Rate FFT Inpatient % Extremely Likely FFT Ward Response Rate Food and Nutrition Nursing Workforce – Plan Compliance Nursing Workforce Day Hours – Plan Compliance Nursing Workforce Night Hours – Plan Compliance Pain Management PALS - Concern Patient Safety Actual Harm Incidents: Level 4-5 Clostridium Difficile - Incidents CPE New Positives CPE Percentage Screened Positive Crude Mortality Crude Mortality - Elective Crude Mortality - Non Elective EWS Alert Response Rate GMC Trainee Survey – Number of low scoring outliers GMC Trainee Survey – Specialties meeting national average Harm: Catheter Associated Urinary Tract Infection Harm: Patient Falls Harm: Pressure Ulcers Harm: VTE HSMR Incidents: Patient Falls: Level 4-5 Incidents: Pressure Ulcers: Grade 3-4 Medication Errors: Level 4-5 Methicillin-resistant Staphylococcus Aureus Never Events Participation of Mandatory National Clinical Audits SHMI Regulatory Framework Community Activity Data Completeness Community Referral Completeness Community RTT Completeness Continuity of Services Rating CQC Rating Governance Risk Rating - Trust	Performance 18 Weeks Specialty Performance - Admitted 18 Weeks Specialty Performance - Incomplete 18 Weeks Specialty Performance - Non Admitted A&E - 4 Hours Arrival to Departure Average Inpatient LOS Days (Excl. Assessment Units) Cancelled Operations 28 day Breaches Cancer 31 Days First Treatment Cancer 31 Days Sub Chemo Treatment Cancer 31 Days Sub Surgical Treatment Cancer 62 Days RTT Cancer 62 Days Screening RTT Cancer Urgent 2 Week Wait Referrals Diagnostic Performance DNA Rate: Follow-up Appointments DNA Rate: New Appointments Elective Actual vs Plan Emergency Admissions - Short Stay Emergency Admissions - Avg. LOS Internal Governance Risk Rating – All Divisions Outpatient Actual vs Plan Percentage of Cancelled Operations RTT - 18 Weeks(Admitted Patients) RTT - 18 Weeks(Incomplete Pathways) RTT - 18 Weeks(Non-Admitted Patients) Ward View Ward: Clinical Mandatory Training Ward: Complaint Volumes Ward: FFT Inpatient % Extremely Likely Ward: Food and Nutrition Ward: Incidents: Patient Falls: Level 4-5 Ward: Incidents: Pressure Ulcers: Grade 3-4 Ward: Medication Errors: Level 4-5 Ward: Nursing Workforce Non-RN Day Hours – Plan Compliance Ward: Nursing Workforce Non-RN Night Hours – Plan Compliance Ward: Nursing Workforce RN Day Hours – Plan Compliance Ward: Nursing Workforce RN Night Hours – Plan Compliance Ward: Pain Management Ward: Sickness Absence Ward: Turnover Human Resources Admin and Clerical Agency Spend Appraisals BME Staff Retention Clinical Mandatory Training Qualified Nursing & Midwifery Vacancies Sickness Absence Staff Retention Time to Fill Vacancy Time to Fill Vacancy - 3mth rolling Turnover Turnover - 3mth rolling

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Michael McCourt Chief Executive, Manchester Local Care Organisation
Paper prepared by:	Tim Griffiths Assistant Director - Corporate Affairs, Manchester Local Care Organisation
Date of paper:	February 2019
Subject:	Manchester Local Care Organisation Update
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Leading on the development and implementation of integrated care.
Recommendations:	The Board of Directors are asked to note the contents of this paper.
Contact:	Name: Tim Griffiths Tel: 07985448165

1. Introduction

1.1 This report provides an update from the Manchester Local Care Organisation to Board of Directors. It covers the following:

- System resilience and escalation;
- New care models;
- Development at neighbourhood level;
- Adult social care improvement programme;
- Engagement;
- MLCO business plan and phase 2; and,
- MFT Scrutiny.

2. System Resilience and Escalation

2.1 Further to previous updates, the MLCO continues to work with MFT with support from Partners such as Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust to support the alleviation of the current flow pressures that the system is facing. This has led to focussed activity on patients with a long length of stay or who are determined to be stranded as per MFT criteria; as well as developing medium to long term system-flow improvement and sustainability plans.

2.2 To date this work has focussed on the pressures at the Manchester Royal Infirmary with the MLCO senior leadership working closely with colleagues to expedite the movement and discharge of patients from an acute to the most appropriate community setting – using our joint role across health and social care to support this. As of 16th February this programme of work had supported the discharge of 129 patients who account for an accumulated length of stay of circa 14,100 days.

2.3 MLCO will continue to respond positively to increased hospital pressures across the city by providing a community managerial presence at hospital sites to support discharge priorities.

3. New Care Models

3.1 The New Care Models (NCM) which the MLCO is responsible for mobilising, continue to progress through the key phases of business case, design, mobilisation, implementation and evaluation. The priority for 2018/19 is threefold and a detailed update is provided against each of the programmes:

- Integrated Neighbourhood Teams
- Manchester Community Response
- High Impact Primary Care

Integrated Neighbourhood Teams

3.2 As previously advised, following an initial consultation period, the MLCO have been actively progressing with an external recruitment process to recruit to 12 INT Lead posts. Following an interview process in November 2018, nine of the 12 posts have been filled. Several of the leads have already started in post with the remainder having start dates set. In regards to the three remaining posts, interviews are taking place week commencing 25th February 2019.

3.3 In addition to the leadership roles outlined above, the MLCO is also in the process of confirming the rest of the INT leadership quintet. In terms of the GP Leads, it has been agreed that these posts will undertake two sessions a week as part of this role, increasing from the one session a week that is currently in place. All of the GP Leads are in place and underwent a two-day leadership session, aligned to the overarching INT development plan, in November 2018. Each of the GP Leads will receive a personalised plan and 2 sessions of coaching to support them in this role. It should be noted that the funding for the GP Leads has only been secured on a one-year basis, with the future funding yet to be agreed.

3.4 In regards to the rest of the roles, the majority of these have now been recruited to. There are six Mental Health Leads who have been assigned two neighbourhoods each. The 12 Nursing Leads have been confirmed and are in the process of being allocated neighbourhoods and the Social Care Leads recruitment process is currently ongoing.

3.5 MLCO is currently working to finalise its neighbourhood operating model, neighbourhood governance arrangements, and accountability and assurance arrangements.

Manchester Community Response

3.6 Manchester Community Response (MCR) is a seven-day service that provides community based intermediate care, reablement and rehabilitation services to patients. These are often older people, after leaving hospital or when they are at risk of being sent to hospital. These services offer an interface between hospitals and where people live, working across the health and social care system. It is an evolution of the highly-effective North Manchester Community Assessment and Support Service. Two component parts of the MCR model are Crisis Response and Discharge 2 Assess services. An update on the mobilisation of these services and some associated activity to date is provided below.

Crisis Response

3.7 The Crisis Response Team, which supports patients who need urgent support at home, but who do not need to be admitted to hospital. The team accept referrals from North West Ambulance Service (NWAS) and the service is being mobilised across the City.

The team provides urgent assessments and interventions for people who have a health or social care crisis, to support people to remain at home, while the crisis situation is addressed.

3.8 The Crisis Response service in Central Manchester went live, 5th November 2018. Although implemented ahead of schedule, due to staffing and recruitment issues only the amber pathway element of the service is operational, with the whole service expected to be operational by March 2019. Work is ongoing with the North West Ambulance Service to increase the referrals and usage of this service further.

3.9 The Crisis Response service launched in part in South Manchester, 3rd December 2018. The community referral element of the model was launched, with there being the aim to operationalise the whole model by March 2019, subject to recruitment. The service is currently operational seven days a week from 08:30 to 18:30, accepting three out of the four available pathways.

Discharge 2 Assess

3.10 Discharge 2 Assess (D2A) helps people home from hospital, quickly and safely. The essence of the approach is that the person, once medically optimised, leaves hospital and is assessed for their ongoing needs in their home or other place of residence. The aim is to reduce unnecessary delays in discharge when people could be back at home or in a more appropriate place to receive ongoing assessment, short term interventions and support from community teams. Funding has been provided to design, implement and roll-out D2A across the entire city.

3.11 The rollout of Discharge to Assess has commenced in both North and South Manchester. The service commenced in North Manchester in May 2018 and South Manchester in September 2018. Similarly, to other care models, there have been recruitment challenges, which have influenced the roll out of the service. Staff continue to be recruited into the teams to deliver the required capacity as quickly as possible.

High Impact Primary Care

3.12 High Impact Primary Care (HIPC) continues to be mobilised across the City of Manchester with there being a HIPC team based in three neighbourhoods, which span across each of the localities. This service is a vital component of local care organisation models and is supported by international evidence in terms of having a positive impact on population health, specifically for those at high risk of admission to acute and secondary care.

3.13 There are numerous patient case studies being collected and shared, demonstrating the quality impact of the service of patients' lives. In terms of quantitative activity data, information has been provided below. From an activity perspective, the service is having a demonstrable impact on the cohort of patients, with the cost of emergency activity reducing by 65%. 75% of the patients discharged from HIPC have had no further emergency activity since discharge. HIPC met its performance targets in both November and December.

3.15 An overview of performance in regards new care models and system escalation is provided at Appendix One.

4. Development at neighbourhood level

4.1 The 12 neighbourhoods are the principal building blocks of MLCO and the volume and intensity of the work to date reflects that. To support the development and production of MLCO Business Plan for 19/20, MLCO has set off a process to compile 12 Neighbourhood plans. The plans will be built within the strategic framework for the MLCO and describe the key activities that will be delivered during 19/20 to deliver the four ways of working in the LCO (i.e. promoting healthy living) and the 10 outcomes described within the Outcomes Framework.

4.2 The plans will outline:

- How the plan was developed and agreed;
- What was delivered by the neighbourhood in 18/19;
- The priorities for delivery in the neighbourhood in 19/20; and,
- Any support that is required to enable the neighbourhood to deliver its priorities.

4.3 The plans will complement and not replace the existing ward planning process that is used across the neighbourhood footprints in Manchester.

4.4 The INT leadership teams will be accountable for the development and delivery of the plans and will work through the existing neighbourhood infrastructure to develop and agree the plan content.

4.5 These plans by their very nature will be iterant and will be revised to reflect the change in need of residents with neighbourhoods. The approach to developing and refining these plans will be heavily reliant on active engagement with stakeholders within neighbours including elected members, communities and their residents, and the voluntary community enterprise sector.

4.6 MLCO is also working with Nesta to roll out the 100-day challenge for neighbourhoods.

4.7 Work is now underway to understand the impact of electoral boundary changes at ward level which is likely to impact on neighbourhood footprints. We are working in partnership to identify how we adopt the new boundaries over time in that work for MLCO and its core partners.

5. Adult Social Care Improvement Programme

5.1 The ASC service level agreement describes a range of Adult Social Care services to be delivered through MLCO. Whilst integration at neighbourhood level is progressing at pace, there is still significant work to do in order to fully assimilate existing governance arrangements that support ASC into MLCO governance. This work is starting to make progress especially with the arrival of a new senior management team. It should be noted that in the same way that MFT retains responsibility for the delivery of community health services, Manchester City Council ultimately retain responsibility for the delivery of Adult Social Care.

5.2 One of the key priorities for MLCO in Quarter Four through 2019/20 will be the delivery of the ASC Improvement Programme. This work will ensure that we are getting the basics right in adult social care and will enabling us to successfully deliver health and social care reform and integration.

5.3 A programme plan for this work is now in place, based on the outcomes of a diagnostic piece of work and will enable the Acting Director of Adult Social Services (DASS) to address performance challenges through the targeted improvement work which will tackle challenges including:

- increase in demand across all services;
- increase in safeguarding enquiries;
- increase in Deprivation of Liberty Safeguards referrals;
- ensuring waiting lists for assessments, reassessments and reviews are kept low; and,
- ensuring that temporary funding doesn't hamper ongoing delivery

5.4 The plan focuses across the service on the core themes of process, practice, workforce and resources, acknowledging that they are interdependent and if considered together will ensure that the right foundations are in place for the service to deliver its statutory duties.

6. Engagement

6.1 Public engagement work has been a core element of the first year of MLCO. This started with the Future Search programme where over 300 staff, partners and residents were involved in 2017 work to shape design of MLCO.

6.2 In year one, the focus has been on partnership working with Manchester Health and Care Commissioning based on engagement around the Manchester Locality Plan. This has been carried out since summer 2018 to boost health engagement capacity in the city, promote MLCO and seek public views on key elements of the plan that will influence future service design and commissioning. MLCO has been directly involved in over 60 events, reaching over 1,000 residents and gaining 520 locality plan survey responses.

6.3 The reports from the survey work are due to be published in February 2019. Other MLCO linked events - such as Health Development Coordinator engagement events in the North of the city in November have taken place and reached around 400 residents and partners. MLCO is an active member of the Bringing Services Together programme led by Manchester City Council that aims to coordinate resident engagement work across the city.

6.4 MLCO have also led an ongoing programme of staff engagement and communications. Our Freedom to Lead event in September 2018 brought together over 200 of our service leaders and team members from across the city and plans are in place to stage a second event in April 2019. The quarterly MFT pulse check survey shows good engagement performance amongst our (MFT deployed) health staff with an overall engagement score of 3.88 (good), 86% of staff understanding the benefits of MLCO to local people and 83% of staff satisfied with the quality of care they provide to local people.

6.5 The results of Manchester City Council's 'Be Heard' annual survey which covers our adult social care deployed staff has recently been published and shows improvements in engagement and other metrics across the board, although more work is required in this area.

6.6 Work is currently underway to develop a MLCO-wide pulse check system to better measure staff views on a regular basis across the integrated team and discussions are underway with MFT on how to progress this. A wider communications strategy for better supporting communications for adult social care staff through MLCO is also being developed.

6.7 A series of drop in sessions took place in February for elected members to meet with the MLCO Executive, understand the progress of MLCO to date and priorities for the coming year.

6.8 As the full Integrated Neighbourhood Team leadership team come together, individual ward meetings will be arranged in March and April for elected members with the relevant INT Leadership Team, and MCC Neighbourhood Manager. The purpose of these meetings will be to:-

- Provide an introduction to the team;
- For Elected Members to outline their priorities in relation to Health and Wellbeing for the ward they represent;
- Outline the ward health profile using data and evidence
- Outline the 19/20 INT Neighbourhood Plans as produced by the INTs and consider opportunities for alignment and joint working between wards and the Neighbourhoods; and,
- Consider the approach to date to develop Neighbourhood Insight and agree how members can input into the content.

7. MLCO Business Plan and Phase 2

7.1 The activity of MLCO in 2018/19 was defined by its Business Plan and the work which was undertaken in collaboration with MHCC that defined a core set of deliverables. Both these documents remain valid and provide the framework for all MLCO activity, although it should be recognised that additional programmes of work and priorities have emerged throughout the course of year, notably the work to support an expedition of the transfer of care for patients with significant lengths of stay in MRI.

7.2 To support the development of MLCO into 2019/20 including the business planning process, a series of 'road maps' (agreed by the MLCO Partnership Board) are in the process of being developed to support further integration including:

- Operationalising INT and locality structures
- Approach to service re-design
- Population Health
- Primary Care
- Adult Social Care
- Mental Health
- Children's
- Commissioning
- MLCO Procurement (Phase 2)
- Enablers
- Resourcing
- OD
- Governance

7.3 The road maps and programmes of work are at different stages of development and by their very nature will have differing mobilisation and development timescales.

7.4 As identified above it is via these road maps that MLCO will be producing an integrated business plan and deliver the services that fall within its ambit on an ongoing basis.

7.5 As the Board will be aware the MLCO will realise its full potential in a three year phased approach as set out in the Partnering Agreement. The majority of services that were transferred in year one were community health services (including North Manchester Community Health Services) and directly provided Adult Social Care.

7.6 Year Two will see a range of other services move under the management of MLCO including a host of commissioned services such as Home Care and Residential and Nursing Care. Work is ongoing, led by Manchester Health and Care Commissioning, to define the approach to be taken to support the further development of MLCO.

8. MFT Scrutiny Committee

8.1 As discussed at the last meeting, MFT oversight of MLCO comes via the MLCO Scrutiny Committee chaired by Kathy Cowell. The last meeting of this committee took place on 22nd January, and received reports on the following:

- Winter resilience and system escalation;
- High Impact Primary Care; and,
- Neighbourhood Target Operating Model;

8.2 The next meeting of the committee is scheduled for 6th March 2019.

9. Recommendations

9.1 The Board is asked to note the contents of this report.

Appendix One

MLCO peformance and updates at a glance

February 2019

Manchester Local Care Organisation

Leading local care, improving lives in Manchester, with you

High Impact Primary Care (HIPC)

Three pilot HIPC programmes across the city providing GP led, integrated community care to most vulnerable residents who are high users of other services.

- User targets for November met with 463 residents accessing HIPC
- User targets for December met with 540 residents accessing HIPC
- Signifiant reductions in use of other services by users
- 75% of clients have had no emergency activity post discharge
- Pilots extended to March 2020.

Up to **60%** reduction in

- GP contacts
- Hospital admissions
- calls to NHS 111
- A&E attendances
- Ambulance calls

amongst HIPC cohort of patients

Escalation and patient flow support

Joint work with team at Manchester Royal Infirmary to support discharge of super stranded patients medically fit for discharge back to community settings with right support.

- Programme of work since August 2018
- Ongoing identification of super stranded patients and coordination work to expedite discharge
- Joint health and social care approach through MLCO team
- Over 110 patients successfully discharged with combined length of stay of over 12,500 bed days
- Contributed to average MRI length of stay reducing by five days.

114 super stranded patients discharged

with a combined length of stay in hospital of

12,806 days

Contributing to a reduction of around five days in average inpatient length of stay at MRI .

Manchester Community Response (MCR)

Umbrella for six programmes of work including Community Crisis Response, Discharge to Assess, Reablement and others that provide short term care to help prevent hospital admission/expedite discharge.

- Central Manchester crisis response team launched Nov 2018 to take NWAS amber pathway referrals
- South Manchester crisis response team launched Dec 2018 to provide community referrals from A&E, AMU, CDU, GPs and social
- Discharge to Assess programmes running in North and South Manchester.

Central Community Crisis Response team since Nov

135 accepted amber referrals from NWAS

116 patients treated in community and avoided A&E/admission

South Community Crisis Response team since Dec

65 referrals accepted from GPs/urgent care and treated in community

Integrated Neighbourhood Teams (INTs)

12 neighbourhood teams, co-locating health and social care services around populations of 30k to 50k residents. Each team has leadership including overall lead and GP, nursing, social care and mental health leads.

- Recruitment to 9 of the 12 overall leads complete
- All 12 GP leads in place as well as nurse and mental health leads
- Estates work to complete hub bases for each INT progressing with 6 complete and others underway/in negotiation
- Didsbury East and West, Burnage and Chorlton Park INT has been an early implementer at Withington Community Hospital since November 2018.

Early work from **Didsbury East & West, Burnage and Chorlton Park INT** early implementer has found:

\+ improved communication between health and social care teams

\+ better understanding of roles, speeding up of assessments and more joint visits

= **better coordinated care for local residents**

Powered by:

NHS Manchester University NHS Foundation Trust

NHS Greater Manchester Mental Health NHS Foundation Trust

Manchester City Council

Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

The Manchester Primary Care Partnership

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Anne-Marie Varney, Acting Group Assistant Chief Nurse (Workforce)
Date of paper:	March 2019
Subject:	Safer Staffing – To provide the Board of Directors with the bi annual Nursing and Midwifery Safer Staffing report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner) 1. Patient Safety 2. Patient Experience 3. Productivity and Efficiency
Recommendations:	To note the work that is being undertaken to ensure the safe provision of a nursing and midwifery workforce
Contact:	Name: Karen Meadowcroft, Corporate Director of Nursing & Anne-Marie Varney, Acting Assistant Chief Nurse Tel: 0161 276 8862

1. Introduction

1.1 The bi-annual, comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust position against the requirements of the National Institute of Health and Care Excellence (NICE) guidance for adult wards issued in July 2014[1],the National Quality Board (NQB) Safer Staffing Guidance 2016[2], NQB Speciality Staffing Improvement Guidance 2018[3] and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[4]. The Guidance recommends that the Board of Directors receive a bi annual report on staffing in order to comply with the CQC fundamental standards on staffing.

1.2 The paper will provide analysis of the Trust workforce position at the end of **December 2018** and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce.

1.3 Workforce modelling has been undertaken to present the information by Hospitals and Managed Clinical Services (MCS). The Hospital/MCS Directors of Nursing and the Director of Health Care Professionals (HCP) are required to present a quarterly a Nursing/Midwifery workforce report to their Hospital/MCS Board. The January 2019 Board reports have been presented to the hospitals/MCS and inform this report.

2. National Context

2.1 Nationally, Nursing and Midwifery workforce supply remains a high priority with the shortfall in nursing being a well-documented challenge for all NHS Trusts. NHSI reported in excess of **41,000** registered nursing vacancies across NHS Trusts, equating to an increase of **3,500** vacancies during the same period in 2017/18[5]. The Royal College of Nursing (RCN) state that more than 37,000 agency workers spend more than 1 year at the same employer, including 2347 nurses and 628 doctors. The RCN have argued that the figures demonstrate an “untenable short staffing crisis” across the NHS[6]. 2.2 The shortage of nursing and midwifery supply has been caused by a number of factors:

- An increase in nurses leaving the profession equating to circa **7,000** more nurses leaving year on year.
- An aging workforce profile, with an increase of nurses and midwives predicted to reach retirement age within the next 5 years.

[1] Safe staffing for nursing in adult in patient wards in acute hospitals July 2014
[2] Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time. National Quality Board, July 2016
[3] NQB 2018 Safe, sustainable and productive staffing: An improvement resource for maternity services
[3] NQB 2018 Safe, sustainable and productive staffing An improvement resource for adult inpatient wards in acute hospitals
[3] NQB 2018 Safe, sustainable and productive staffing An Improvement resource for the district nursing service
[3] NQB 2018 Safe, sustainable and productive staffing An improvement resource for learning disability services
[4] Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement (2018)
[5] National data on workforce. NHS Improvement (2018)
[6] Obtained from FOI RCN 2018

- The uncertainty of the impact on Brexit and the impact on the number of European Union (EU) nurses applying to join the NMC register and leaving the NHS. In 2018 the number of EU nurses and midwives leaving the NMC register increased by 30%. Over the same time period the number of EU nurses and midwives joining the register dropped by 87% (805 EU midwives and nurses joined the register compared with 6382 the year before)[7]

2.3 In January 2018, the House of Commons' Health and Social Care Committee[8] considered the impact of the shortage of Registered Nurses, calling upon the Government to expand the nursing workforce at scale and pace, increase opportunities for CPD, monitor the impact of the removal of the bursary and provide a clear professional identity for the Nursing Associates (NA). The government published an official response to the committee's recommendations in July 2018[9] outlining a number of initiatives which include:-

- Retention of nurses
- Increase supply of newly qualified nurses
- Introduction of the role of Nursing Associates
- Programmes to support overseas recruitment
- Workforce planning
- Support for return to practice initiatives

2.4 In January 2019, NHS England published the NHS Long Term Plan (LTP), setting out an overall vision for how the NHS should change over the next ten years. The plan acknowledges the key role of staff in the NHS and the role that employers play in ensuring staff can deliver care to patients. A workforce implementation plan will be published later in 2019, providing clarity on the funding available for additional investment in workforce, training, CPD and flexible working. The plan acknowledges that the NHS needs to move to an overall increase in supply with the aim of reducing the nursing vacancy rate to 5 per cent by 2028 with an increase in undergraduate training places and further expansion of 7,500 nursing associates starting in 2019.

2.5 The LTP highlights some of the current workforce issues and proposes a number of actions. However, most of these actions will take time to deliver and much is left to the new national workforce group and forthcoming workforce implementation plan to address. Further information will be presented to Board of Directors and the HR Scrutiny Committee following the publication of subsequent documents later in 2019.

3. Greater Manchester Context

3.1 The success of the collaboration in GM between the Chief Nurses and Higher Education Institutes (HEIs) across GM has resulted in an overall 10% increase in the number of Nursing & Midwifery students commencing a programme of education in the academic year 2018/19, in comparison to programmes of education in 2016/17 prior to the removal of the bursary. Training lead times however, mean new investment in staff will not deliver additional supply in the workforce for at least three years.

[7] NMC 2019, nmc.org.uk
[8] House of Commons Health and Social Care Select Committee 2018, The Nursing workforce. 2nd Report of Session 2017.19
[9] Sec State for Health July 2018, Government response to House of Commons Health and Social Care Select Committee 2018, The Nursing workforce. 2nd Report of Session 2017.19

3.2 The GM Organisations have commissioned 360 Trainee Nursing Associates apprenticeships for 2019/20 to be delivered through the partner HEIs.

3.3 The GM Nurse Recruitment campaign, 'Bee a Greater Manchester Nurse'[10] concluded at the end of November 2018; an evaluation of the impact of the campaign is currently being undertaken to inform phase 2 of the campaign. An additional HEI Student Nurse Recruitment campaign funded by the 4 GM HEIs is currently being finalised to attract students to train in GM and is expected to be launched in March 2019.

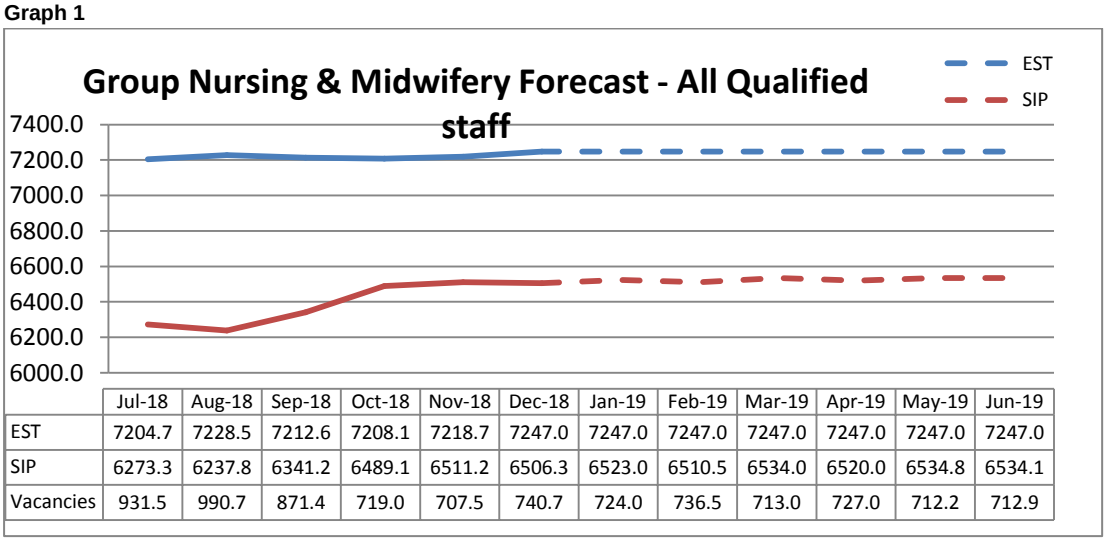
4. MFT

4.1 Trust Workforce Position

4.1.1 At the end of December 2018, there were a total of **740.7wte (10.2%)** qualified Nursing and Midwifery vacancies across the Group compared to **990.7wte (13.7%)** at the end of August 2018. This is a reduction in the overall Nursing and Midwifery vacancies of **250.0wte (3.5%)** since August 2018.

4.1.2 **Graph 1** provides the overall Nursing and Midwifery vacancy trajectory until the end of Quarter 1 (2019). The Nursing and Midwifery vacancy position is much improved from the same period in the previous year with an additional **120wte** nurses and midwives in post. The workforce modelling undertaken in December 2018 predicts that there will be **713wte (9.8%)** nursing and midwifery vacancies at the end of March 2019. The vacancy position is expected to remain unchanged and potentially improve in Q1 (previous years the vacancies have increased) which is due to the increase of International Nurses.

Graph 1



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	7204.7	7228.5	7212.6	7208.1	7218.7	7247.0	7247.0	7247.0	7247.0	7247.0	7247.0	7247.0
SIP	6273.3	6237.8	6341.2	6489.1	6511.2	6506.3	6523.0	6510.5	6534.0	6520.0	6534.8	6534.1
Vacancies	931.5	990.7	871.4	719.0	707.5	740.7	724.0	736.5	713.0	727.0	712.2	712.9

[10] https://www.greatermanchesternurses.co.uk

4.1.3 The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of December 2018 there were **554.5wte (13.9%)** staff Nurse (band 5) vacancies across the Trust compared to **743.6wte (18.7%)** at the end of August 2018. This is a reduction of **189.1wte (4.8%)** nursing and midwifery band 5 vacancies.

4.1.4 **Graph 2** illustrates the Group-wide band 5 workforce position until June 2019. The number of band 5 nursing and midwifery vacancies is expected to increase in Q1 due to a reduction in the domestic recruitment pipeline which is known to occur at this time. This position will improve from September 2019 following the graduation and appointment of newly qualified Nurses and Midwives in Q3.

Graph 2

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	3949.1	3968.0	3966.9	3966.6	3966.4	3983.1	3983.1	3983.1	3983.1	3983.1	3983.1	3983.1
SIP	3244.4	3224.4	3308.4	3430.5	3431.1	3428.5	3437.2	3426.4	3435.1	3421.1	3412.4	3407.4
Vacancies	704.7	743.6	658.4	536.1	535.3	554.5	545.9	556.6	548.0	562.0	570.7	575.7

4.1.5 The predicted increase in the number of International Nurses in the next 12 months and the nursing skill mix review to support the introduction of the Nursing Associate role from February/March 2019, provides an additional workforce supply which has not previously been available and will support the Group band 5 nursing workforce position. It is predicted that the number of band 5 vacancies at the end of March 2019 will be **548.0wte (13.7%).** This will be an improvement to the position in March 2018 when the vacancy factor was **16.2%.**

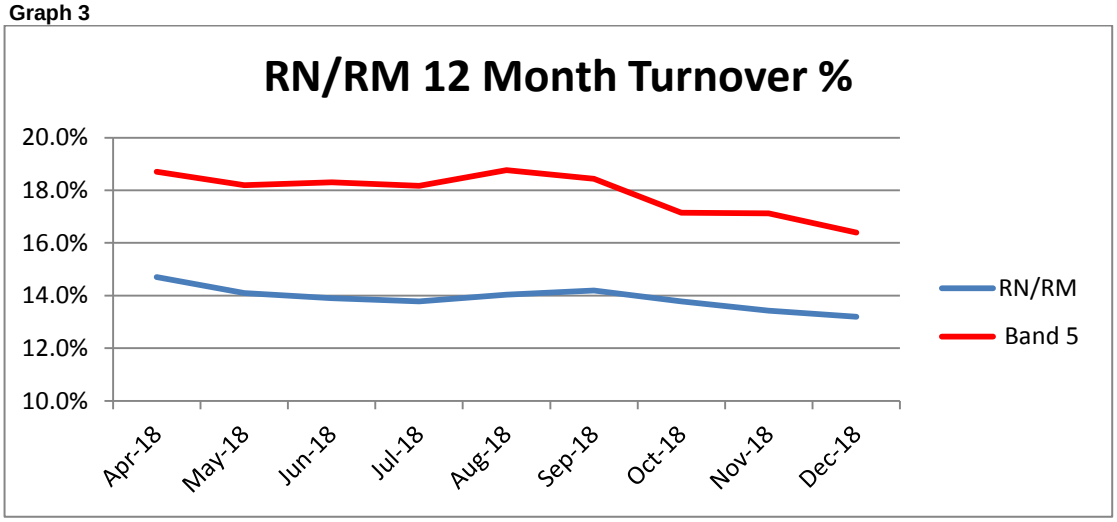
4.1.6 It should be noted that whilst the band 5 Nursing and Midwifery vacancy position is expected to increase during Q1, the overall nursing and midwifery vacancy rate is expected to improve. The workforce modelling is based on workforce trends. Historically the number of leavers and turnover is reduced in Q4 therefore it is predicted that band 5 staff are more likely to be promoted to higher bands rather than leave. This together with the additional International workforce should provide a positive impact on the nursing and midwifery workforce trajectory.

4.1.7 When reviewing the number of Nurses leaving the Trust the highest attrition is found to be in Emergency Departments, Theatres, medical assessment units, medical specialities and Paediatric Critical Care. There is no correlation between the number of leavers and high vacancies as each of these areas are able to attract nurses into the specialisms and have undertaken recruitment campaigns within the last 6 months. It is noteworthy that many nurses move to these areas internally from wards and departments. Work is focusing on improving the retention of staff in these areas.

4.2 Group Retention and Turnover

4.2.1 At the end of December 2018, the 12 month rolling turnover rate for Nursing and Midwifery was **13.2%** and **16.4%** within the band 5 workforce (national turnover rate for band 5 nursing and midwifery is 20.6%). As **Graph 3** illustrates, this has improved over the last 9 months when RN annual turnover was 14.7% and band 5 turnover was 18.7%.

Graph 3



4.2.2 Staff reasons for leaving are declared on the termination form completed by individual managers. The data demonstrates that 23% of Registered Nurses and Midwives leave the Organisation without a documented understanding of the reason which highlights the need for a focused piece of work in this area. The completion and use of the exit data is an area for review at Hospital/MCS and Trust level in order to gain a better understanding of why people leave and in turn improve retention amongst this staff group. The 2 highest known reasons for nurses and midwives leaving the Trust are relocation and work life balance, which is particularly evident within their first 5 years in post. Staff wellbeing, incorporating work life balance, is the focus in Q4 within "*Bee Brilliant"* and teams are currently reviewing and implementing positive changes before showcasing their work in early April.

4.2.3 In January 2019 a Retention Workshop was held with the Hospitals and MCS Directors of Nursing and Human Resources Directors to agree a programme of work to improve nursing and midwifery retention. An update on this work programme will be reported to the HR Scrutiny Committee in June 2019.

4.3 Brexit

4.3.1 The impact of Brexit has resulted in a 90% decrease in NMC applications from nurses within the EU and the number of nurses leaving the register has doubled over the last 2 years. The Trust currently employs 330wte Registered Nurses and Midwives from the EU which equates to 5.2% of the Registered Nursing and Midwifery workforce. Over the past 2 years, the Trust has reported a turnover rate of 28.3% within the EU national nursing and midwifery staff group against an average turnover of 13.7% for UK nationals. Despite recent developments within Brexit planning, an increase in turnover has not been noted over the last 12 months. The Trust will continue to monitor this on a monthly basis going forward as part of the Trusts Brexit planning.

4.3.2 The Trust has participated in the Home office beta testing phase for the EU Settlement scheme. All EU nationals have been written to inviting them to a Home Office engagement event and appointment enabling them to apply early for their post Brexit immigration status

4.4 Sickness Absence

4.4.1 The delivery of safe and effective nurse staffing is directly impacted on by the absence of staff. This absence also impacts on delivering financial sustainability across the Trust. There has been a gradual increase in sickness absence within the nursing and midwifery staff group over the last six months with a peak in November 2018. In December 2018, sickness absence was reported at 5.22% with 4.88% reported over the previous 12 month period against the Trust target of 3.6%. Significant work has been undertaken by senior nursing and HR teams within the hospitals and MCS to review sickness absence and ensure robust processes for monitoring and managing this in line with Trust policy. This is further supported by programmes of well-being, resilience and self-care for both physical and mental health, including the "*Bee Brilliant"* focus on staff wellbeing.

4.5 Recruitment

Domestic Recruitment

4.5.1 Trust wide recruitment campaigns continue to attract experienced nurses as well as newly qualified Nurses and Midwives due to qualify in March 2019 and September 2019. There are circa **181** nurses, both newly qualified and experienced registered nurses with conditional job offers whose appointments are being processed through the Trust recruitment process. Over 60% of these recruits are Student Nurses and Midwives who will qualify in March and September 2019. There is usually an attrition rate of 30% from offer to appointment as some students who accept job offers prior to graduating and then subsequently withdraw from the recruitment process accepting a post with another Trust. The Hospital/MCS Directors of Nursing and recruitment leads have implemented a series of interventions to keep appointed staff engaged with the Trust in order to reduce this rate.

International Recruitment

4.5.2 The Trust has a successful International Recruitment Programme which has resulted in an increase in the number of International Nurses joining MFT. A total of **107** International Nurses have commenced in post since April 2018 with a further **75** Nurses expected to arrive before the end of June 2019. This is a significant increase on the number of Nurses recruited in previous years (total **142** Nurses expected compared to 40 Nurses the previous year). Since the start of the IR programme there has been a total of **281** International Nurses join the Trust in the last 3 years. The Trust is regarded by the NMC as being an exemplar site in successful delivery of the IR OSCE programme with an overall pass rate of 98%.

4.5.3 The Trust International Recruitment Programme will continue with bi-annual (February and September) recruitment trips to India and United Arab Emirates. The next event is planned for February 2019.

4.6 Nursing Associates

4.6.1 In September 2016 the Trust, as part of the GM partnership, became a pilot site to train and develop the role of the Nursing Associate (NA) which is a regulated role by the Nursing and Midwifery Council from January 2019. The first cohort of **76** Nursing Associates will completed their training programme in February 2019. It is expected that this group will start to receive their NMC registration from February 2019 onwards.

4.6.2 The NA will not replace the Registered Nursing workforce but will underpin the workforce and address the skills gap between Nursing Assistants and Registered Nurses. Work has been undertaken within the hospitals to profile the introduction of the NA role in the skill mix within the clinical areas to ensure inclusion is safe and appropriate. A detailed Quality Impact Assessment (QIA) has been completed in order to mitigate any potential risks.

4.6.3 There are currently **132** Trainee Nursing Associates (TNAs) in training across the Group of which 80 are due to qualify in April 2020. Up to **120** TNAs will be recruited each year moving forward with an April and September cohort.

4.7 Under graduate Pre-Registration Nursing and Midwifery Training

4.7.1 The Higher Education Institutions (HEIs) have recruited an additional 136 Nursing and Midwifery students in the current academic year, in comparison to programmes of education in 2016/17 which was prior to the removal of the bursary. This does not meet the additionality request from the GM Directors of Nursing, however there is an improved picture for GM and there will be an additional 153 Nursing and Midwifery Students in training in comparison to the previous year with at least 85 students (across adult, child and midwifery fields) undertaking their placements within MFT.

4.7.2 For Midwifery, the GM target for the HEIs is to sustain the previous increase to historic commissioned numbers and recruit an additional 30 midwifery students to meet the workforce requirements across GM. The overall outcome will be to see an additional 90 qualified midwives over the next 3 years.

4.7.3 From February 2019, MFT will have an additional 20 newly qualified nurses commence employment across the organisation year on year, following a collaboration with the University of Bolton. This programme which was commissioned by MFT in 2016 to increase nursing numbers has been extremely successful and will continue.

4.8 Safe Staffing

National guidance

4.8.1 In 2016, the NQB outlined the expectations and framework within which decisions on safe staffing levels should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis[11]. In October 2018, NHSI built upon this with the publication of the Developing Workforce Safeguards Guidance[12], designed to help Trusts manage common workforce problems. The document contains recommendations to be actioned from April 2019; to support a triangulated approach to deciding staffing requirements, combining evidence based tools, professional judgement and outcomes that are based on patients' needs, acuity, dependency and risks.

Planned versus Actual Staff on Duty

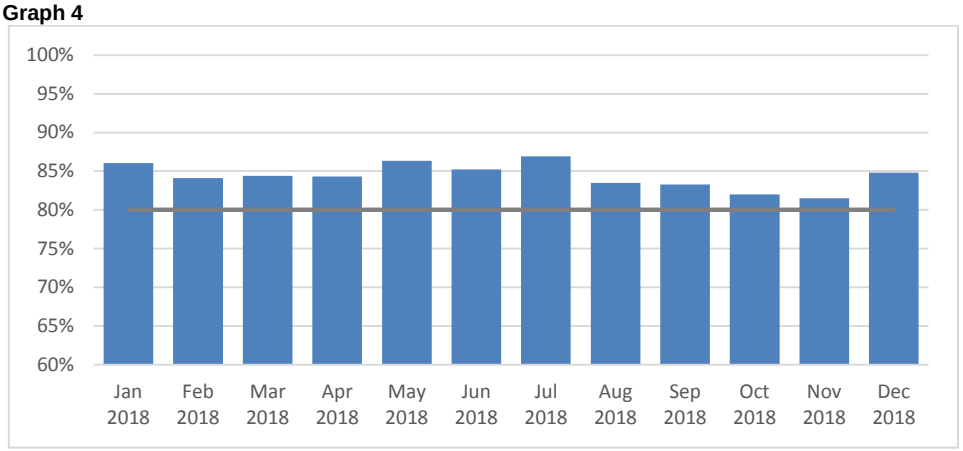
4.8.2 In line with the NQB requirements the Trust publishes nursing and midwifery staffing data on a daily basis at entrances to wards, using 'data at the door' poster boards. The 'Safe Staffing Report' (previously Unify Report) is submitted monthly to NHSI detailing the planned and actual staffing levels and Care Hours Per Patient Day (CHPPD) which is extracted from the Health Roster System. Work has commenced to report the safe staffing data with the Friends and Family Test (FFT) and Harm Free Care data to triangulate staffing requirements and patient outcomes. A monthly report will be provided to the Directors of Nursing, Midwifery and HCP who will monitor patient outcomes and report to their Hospital/MCS Board.

4.8.3 **Graph 4** illustrates the Trust actual registered Nurse/midwifery staffing levels as a percentage against those that were planned (fill rate).

[11] Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time. National Quality Board, July 2016

[12] Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement (2018)

Graph 4



4.8.4 Since July 2018, an average registered nurse/midwifery fill rate of **83.4%** has been reported across the Trust. Daily reviews of staffing requirements are undertaken by senior nursing and midwifery staff at the daily 'staffing huddles'. Escalation processes are in place to mitigate the impact of when planned staffing levels are not achieved to ensure the safe delivery of care.

4.8.5 Where registered nurse fill rates have dropped below 80% and this cannot be resolved staff are redeployed from other areas following a clinical risk assessment and the application of professional judgement based on the acuity and dependency of patients in each area. Additional Nursing Assistant levels are increased in some areas to support this shortfall and provide care and enhanced supervision for less acute but dependent patients. These processes are reviewed by the Directors of Nursing for each Hospital/MCS on a weekly basis.

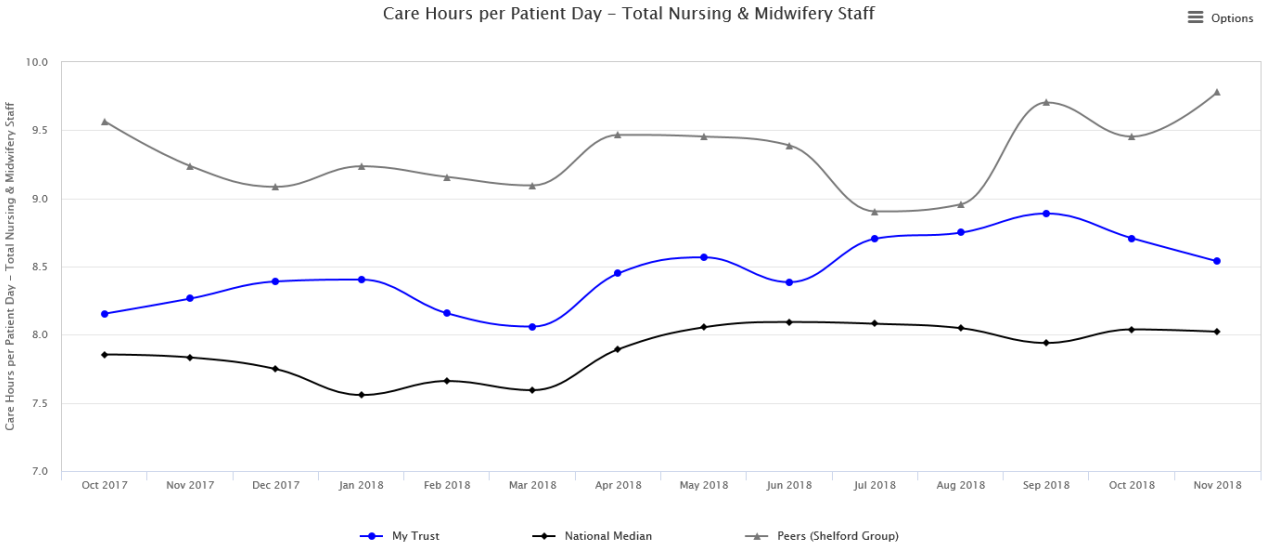
Care Hours Per Patient Day (CHPPD)

4.8.6 From April 2016, all Acute Trusts were required to report monthly staff fill rates and Care Hours Per Patient Day (CHPPD) via the NHS I monthly Safe Staffing report. CHPPD is a metric to reflect care hours per patient bed day and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight.

4.8.7 CHPPD is a simple measure it is not a metric to determine registered nurse requirements or provide assurance for safe staffing. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety.

4.8.8 There is no national target for CHPPD however NHSI publish the data on the NHSI Model Hospital portal in order for Trusts to benchmark the data against other organisations. **Graph 5** illustrates the monthly Trust CHPPD data against the median level across all NHS Trusts and those within the Shelford Group. The MFT Trust wide average CHPPD level is **8.7** hours per patient against a national average of 8.0 hours and a Shelford average of 9.3 hours indicating that the Trust staffing levels result in a CHPPD level within 0.5 hours of the Shelford average. The lack of national CHPPD targets limits the validity and use of this data to inform safer staffing decisions. However the improved staffing levels across the Trust can also be realised in our improvement in the CHPPD indicator.

Graph 5



Daily Staffing Review

4.8.9 Since 2015 the Trusts has collected nursing and midwifery staffing data electronically through the Allocate Health Roster and SafeCare system. The use of both these measures is regarded as acceptable on the basis they record the staffing requirements of patients in real time rather than using a methodology of aggregated data to determine the overall establishments. Patient acuity data is entered into the SafeCare module to provide an indication of the real time staffing levels required based on the acuity of the patients on the ward. These required hours are then compared to the planned staffing on the roster at the daily staffing huddles to identify any potential safety issues and inform senior nurse decisions regarding the redeployment of staff.

Nursing Establishment Reviews

4.8.10 The Shelford Safer Nursing Care Tool (SNCT) is an evidence based tool that calculates nurse staffing requirements based on the acuity and dependency of the patients on a ward and is linked to nurse sensitive outcome indicators. The tool has been validated using a substantial database over a number of years and is now widely accepted by Chief Nurses as the tool of choice for informing ward establishments. The tool has been supported and endorsed for use by NHS England and NHSI following the publication of the NHSI Developing Workforce Safeguards.[13] This will be used to support the nursing establishment reviews that will be undertaken across all inpatient wards from April 2019.

4.8.11 Effective workforce planning is vital to ensure appropriate levels and skill mix is available to deliver safe high quality care. NHSI recommend that establishment setting should be completed annually using evidence based tool and should take into account:-

- Acuity and dependency of patients
- Seasonal variation and demand
- Service development and change

4.8.12 The SNCT tool will be used across the Trust to support nursing workforce establishment reviews. The first census data period will be introduced in March 2019 and patient acuity and dependency data will be collected for a period of 20 days. Data will continue to be collected quarterly to allow for seasonal variations.

4.8.13 Establishment recommendations will be calculated utilising the metrics recommended by the SNCT, and Directors of Nursing will be required to use these calculations to support future establishment reviews. It is expected that following the second census period establishment reviews will be undertaken and an update will be provided to the Board of Directors in September 2019.

Red Flags and Escalation

4.8.14 Both NICE and NHS I guidance recommends Trusts have a mechanism to capture 'red flag' events such as shortfalls in staffing and omissions in care. All wards/departments across the Trust currently have the aforementioned red flags within their templates on SafeCare, however these are not currently being used consistently across the Trust. In addition to senior nurse daily staffing huddles, staff are completing an incident report when staffing levels are below the required parameters which are reviewed by the Directors of Nursing and appropriate action taken. Work is currently underway to embed the process of red flags and training is been provided to ward managers and teams. Following submission of a red flag a senior nurse review will be undertaken and any staffing shortfalls addressed to ensure any potential risks are mitigated or escalated appropriately.

[13] Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement (2018)

The submission of red flags will be monitored through the monthly Health Roster KPI report to ensure adequate reporting.

4.9 Maternity Safe Staffing

4.9.1 In 2017 the NQB published an improvement resource to achieve safe, sustainable and productive staffing of maternity services[14]. This resource is designed to be used by those working in clinical settings and leading maternity services. The Guidance endorses Birth-rate Plus (BR+) Midwifery Workforce Planning which is based upon the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women in the higher clinical need categories. A BR+ study assesses the midwifery workforce of a service based upon the needs of women and records data for a minimum period of 3 months on intrapartum care, hospital and community activity and all other aspects of care provided by midwives from pregnancy through to postnatal care[15].

4.9.2 The Obstetric Strategy for Managing Capacity and Demand has used local intelligence and professional judgement and cross referenced the outputs with the Birth-rate Plus ratios to agree midwifery establishments.

4.9.3 The table below details the midwife to birth ratio for the St Mary's MCS. The table demonstrates the midwife to birth ratio complies with national recommendations of 1:28.

St Marys Managed Clinical Service	No. births per annum	Midwife to Birth Ratio January 19	National Benchmark
Oxford Road Campus	9279	1:29	1:28
Wythenshawe	4235	1:26	1:28

4.10 Safe Staffing Tool for Community Services

4.10.1 The Manchester Local Care Organisation (MLCO) has been working with community health partners to look at a methodology for measuring staffing levels and skill mix within community services. Preliminary fact finding has taken place to ascertain what IT systems are available to support the development of an electronic safe staffing tool for community services whilst providing interoperability with the EMIS IT system which is being rolled out across community services.

4.10.2 In order to ensure safe staffing levels there are a number of mechanisms in place across services to monitor and manage caseloads including individual caseloads being monitored on a daily basis and issues escalated to team managers; and teams working collaboratively to share resources and manage caseloads safely with temporary staffing being utilised when required.

[14] NQB 2018 Safe, sustainable and productive staffing: An improvement resource for maternity services
[15] NICE 2015, NICE guideline NG4: Safe midwifery staffing for maternity settings https://www.nice.org.uk/guidance/ng4

4.10.3 Within the Health Visitor (HV) service a weighting tool is applied across generic HV caseloads to reflect indices of deprivation. Caseloads are reviewed regularly with Team Leads and Heads of Service closely overseeing caseloads.

4.10.4 The EMIS IT system also enables scheduling of visits to allow earlier escalation in relation to concerns raised regarding caseload. With the establishment of the MLCO Safer Staffing Group there is an opportunity to ensure a standardised approach across services and sharing of good practice.

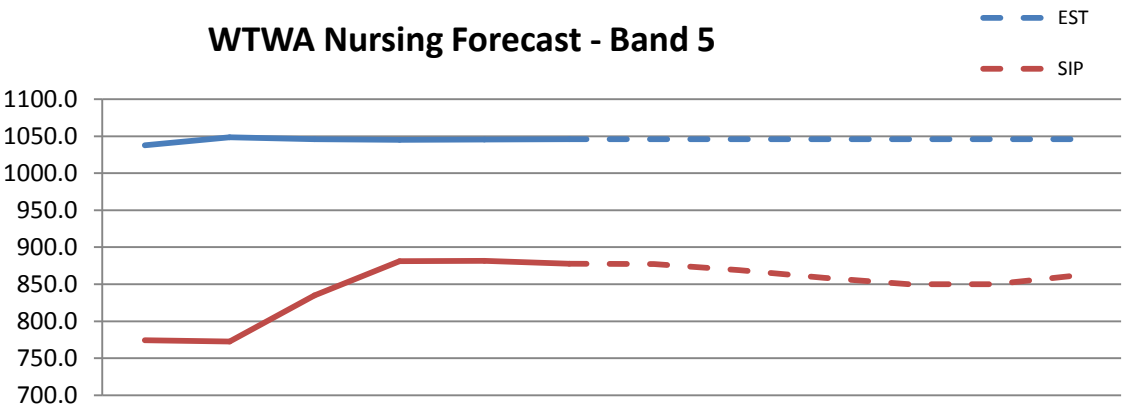
5.0 Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)

5.1 WTWA Workforce Position

5.1.1 At the end of December 2018, there were a total of **192.7wte (10.6%)** qualified nursing vacancies across WTWA. This is a reduction in overall nursing vacancies of **154.1wte** since August 2018. The Hospitals vacancy position is expected to increase by the end of Q1 when it is predicted there will be **200.4wte (10.9%)** vacancies. This will be an improvement on the same period in the previous year and a reduction of **127.1wte** vacancies **(7%)**.

5.1.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce. **Graph 6** illustrates the WTWA band 5 workforce position until June 2019. At the end of December 2018 there was **168.2wte (16%)** band 5 vacancy which is a reduction of **108wte (10.3%)** vacancies since August 2018. The vacancy position is predicted to increase in Q1 to **183.6wte (17.5%)**. This will be an improvement on the same period in the previous year and a reduction of **67wte** vacancies **(5.5%)**. This will improve in Q3 following the graduation and appointment of newly qualified Nurses.

Graph 6



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	1037.8	1048.6	1046.0	1045.3	1045.8	1045.9	1045.9	1045.9	1045.9	1045.9	1045.9	1045.9
SIP	774.1	772.4	835.0	881.1	881.5	877.6	877.1	868.9	858.5	849.9	850.1	862.3
Vacancies	263.7	276.2	211.0	164.2	164.3	168.2	168.7	176.9	187.3	196.0	195.8	183.6

5.1.3 There are **67** Band 5 Staff Nurses currently in the domestic recruitment pipeline to start at WTWA, with 33 due to commence employment at before the end of March 2019. In addition, 16 internationally recruited nurses are due to start in the hospital in early February 2019.

5.1.4 Respiratory, elderly medicine, INRU, orthopaedics and general theatres are difficult to recruit to areas within the Hospital and are aligned to national trends. Vascular surgery at Wythenshawe and elderly medicine across both Trafford and Wythenshawe hospitals are the only areas with Registered Nurse vacancies above 20%. Vascular surgery has noted a reduction in Registered Nurse vacancies and is looking at piloting new roles to support the nursing care model, including the ward based Pharmacy Technician. Across elderly medicine, new ways of working and skill mix reviews are also being implemented. This includes the Nursing Associate role, activity co-ordinators and working in partnership with the AHP Lead to develop the rehabilitation and support worker roles. On the Wythenshawe site, current nursing models and establishments are under review across the North/South wards, to identify opportunities to improve efficiency and productivity, whilst strengthening the skills and competencies of the nursing workforce in acute elderly care. In addition WTWA have run bespoke recruitment drives for elderly care, including the development of a local video to promote the specialty. WTWA continue to explore opportunities to develop rotational posts across Wythenshawe and Trafford. Across all areas within WTWA the focus continues on retention.

5.1.5 There are 25 Nursing Associates expected to start in their new roles in the next 2 to 3 months on successful completion of the TNA programme. The Nursing Associates have been employed to work across the medical and surgical wards at Wythenshawe and Trafford Hospital to allow the opportunity to establish the role within these areas. Work is underway to look at developing the role in Theatres and endoscopy in preparation to introduce the role within these areas within the next 12 months.

5.1.6 The rolling 12 month turnover for nursing is **12.8%** across WTWA with the highest turnover rate in the Division of Medicine (17.6%). The turnover for band 5 Staff Nurses is currently **16.4%.** Since August 2018 the turnover rate for nursing has reduced by 3% which has resulted in **24wte** less nurses leave in Q3 than the previous quarters in the year.

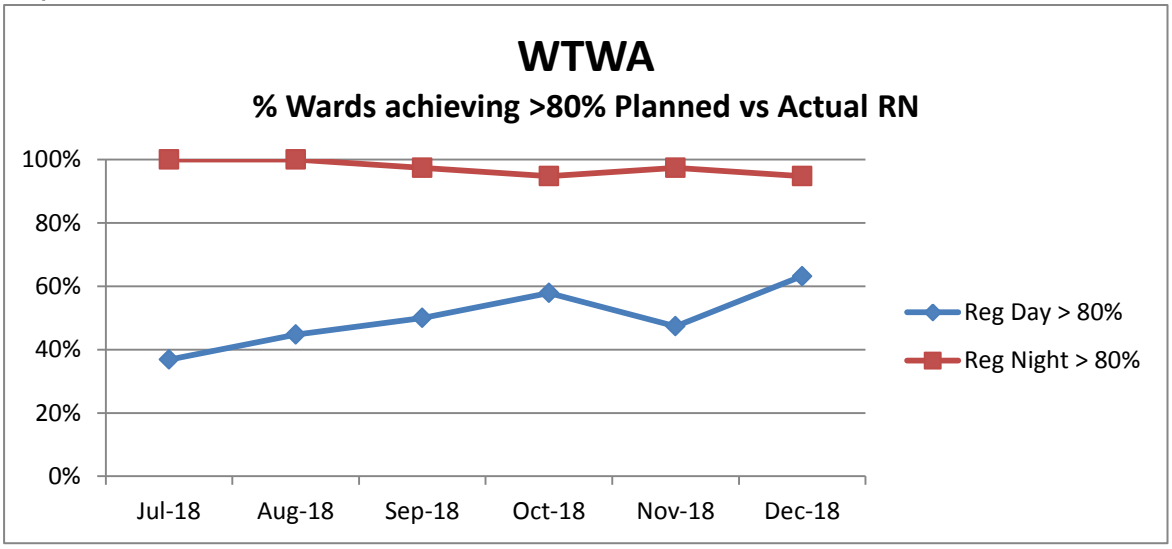
5.1.7 As reflected in the Trust wide position, there has been a gradual increase in sickness absence within the nursing and midwifery staff group at WTWA over the last six months with a peak in November 2018. The highest sickness absence is within Trafford hospital, which was 9.5% in November 2018.

5.2 WTWA Safe Staffing

5.2.1 Across WTWA **86.2%** of planned Registered Nurse shifts are filled. **Graph 7** shows that 37 of the 38 wards at WTWA are achieving more than 80% planned Registered Nurse staffing levels during the night. There are 19 of the 38 wards achieving 80% planned Registered Nurse staffing levels during the day shifts. Priority has been given to ensure the night shifts are adequately staffed when staffing numbers are reduced and less senior cover is available within the hospital. This has resulted in a reduction in day shifts being filled although an improvement in achieving 80% of planned Registered Nurse staffing levels has been noted over recent months.

5.2.2 Following the commencement of both graduate and internationally recruited nurses in September and October 2018, Trafford wards have noted an increased Registered Nurse fill rate from 67% to 80% during the day. The elderly medical and orthopaedic wards have the lowest Registered Nurse fill (actual staffing) rate, retrospectively averaging 70% and 65% per month during the day. To ensure patient safety and support the Registered Nurse workforce these areas have additional Nursing Assistants on duty with a 100% fill rate.

Graph 7



5.3 Key Actions

5.3.1 A number of Divisional retention programmes have been developed within WTWA focusing on staff engagement, training and development opportunities and rotational programmes. Work is also underway to identify reasons for staff leaving and earlier interventions to retain those staff members.

5.3.2 Key work streams have been identified by the Director of Nursing focusing on succession planning and career development and retention of staff (see appendix 1) Each WTWA Head of Nursing will complete a 2019/20 Divisional delivery plan aligned to the workforce priorities set out in WTWA Nursing workforce Strategy.

Progress and professional outcomes will be monitored through the WTWA Nursing workforce Forum chaired by the Director of Nursing.

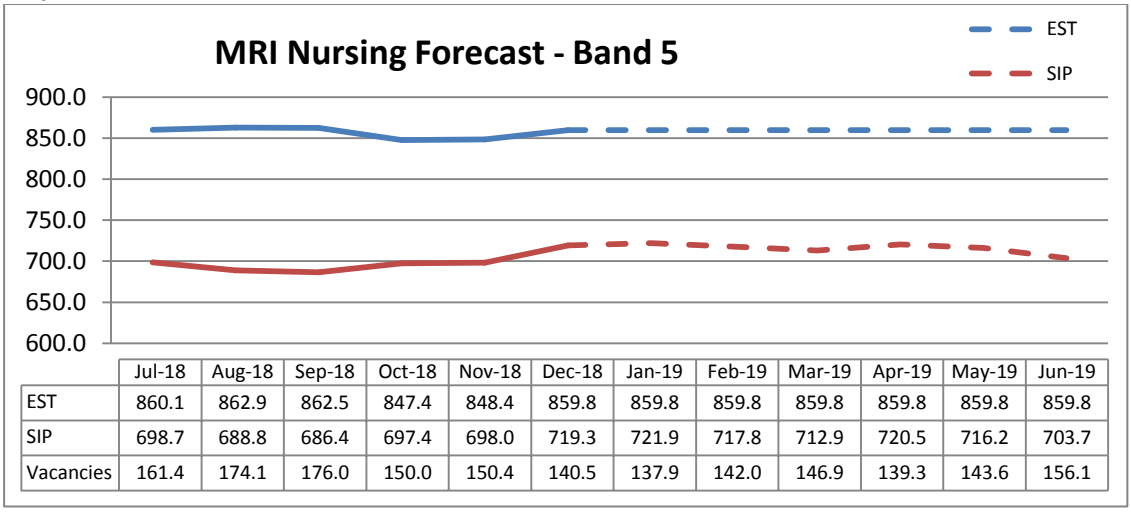
6.0 Manchester Royal Infirmary (MRI)

6.1 MRI Workforce Position

6.1.1 At the end of December 2018, there were a total of **197.2 (12.7%)** registered nursing vacancies across MRI. This is a reduction in overall nursing vacancies of **23.6wte (1.4%)** since August 2018. The Hospital vacancy position is predicted to improve in Q1 when it is predicted there will be **184.2wte (11.8%)** vacancies due to the International and domestic nurse pipeline. This will be an improvement on the same period in the previous year and a reduction of **26wte** vacancies **(2.4%)**.

6.1.2 The majority of the vacancies are within the staff nurse (band 5) workforce**. Graph 8** illustrates the MRI workforce position until June 2019. At the end of December 2018 there was **a 140.5wte (16.3%)** band 5 vacancy which is a reduction of **33.6wte (3.8%)** vacancies since August 2018. The vacancy position is predicted to increase in Q1 to **156.1wte (18.1%)**. This will be an improvement on the same period in the previous year and a reduction of **14.2wte** vacancies **(1.7%)**. This will improve in Q3 following the graduation and appointment of newly qualified Nurses.

Graph 8



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	860.1	862.9	862.5	847.4	848.4	859.8	859.8	859.8	859.8	859.8	859.8	859.8
SIP	698.7	688.8	686.4	697.4	698.0	719.3	721.9	717.8	712.9	720.5	716.2	703.7
Vacancies	161.4	174.1	176.0	150.0	150.4	140.5	137.9	142.0	146.9	139.3	143.6	156.1

6.1.3 There are **44** Band 5 Staff Nurses currently in the pipeline to start at MRI, with 27 due to commence employment before the end of March 2019. There are **26** Nursing Associates expected to start in their new roles in the next 2 to 3 months on successful completion of the TNA programme. In addition, a cohort of **25** internationally recruited nurses is due to start in the Hospital in March 2019.

6.1.4 Within the wards and departments at the MRI there are 12 wards that have a Registered Nurse vacancy rate above 20% including respiratory, elderly medicine, haematology, renal, hepatobiliary and surgery. The Hospital continues to focus on the identity of the Manchester Royal Infirmary and the services that the Hospital provides. Specific actions have been taken to enhance recruitment to these specialities through the implementation of an acute medical rotation which has resulted in an increased number of applicants. To ensure the delivery of safe patient care, temporary staff are utilised to fill vacant shifts against the planned staffing requirements within each ward/clinical area. Workforce plans have been developed to cohort the Nursing Associates qualifying in February 2019 across some of these ward areas to support a reduction in vacancies and the integration and development of the role. Longer term, work is underway to look at developing the role in Theatres, endoscopy and ED in preparation to introduce the role within these areas within the next 12 months.

6.1.5 The 12 month turnover for nursing within MRI is **15.1%** with the highest turnover in the Division of Medicine (15.8%). The turnover within the Staff Nurse workforce is **18.8%** with the highest turnover also in the Division of Medicine (**22.6%**). Since August 2018 the turnover rate of band 5 staff nurses has improved resulting in a 4% reduction.

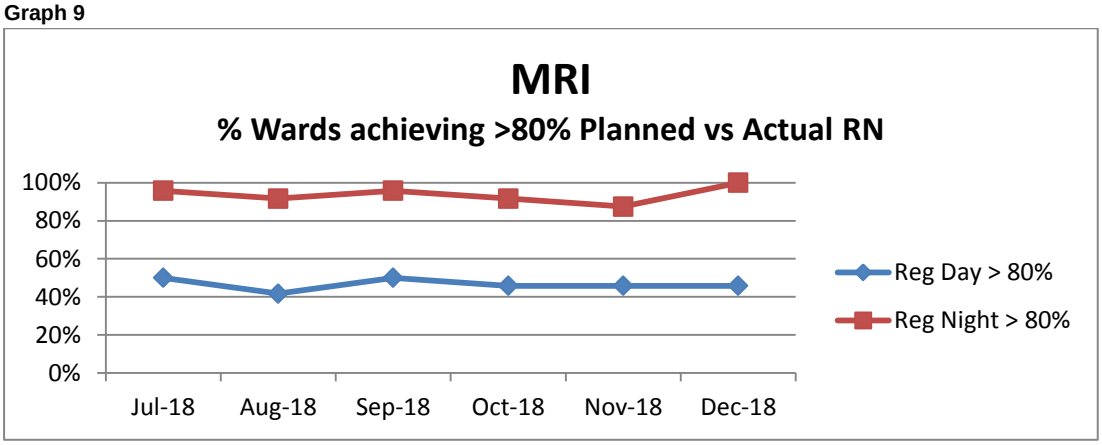
6.1.6 Registered Nurse sickness absence levels have seen an increase across MRI as a whole, particularly in November 2018 when it was **6.6%.** The highest sickness absence is within the Division of Surgery, which was 7.0% in November 2018. The delivery of safe and effective nurse staffing across MRI is directly impacted on by the absence of staff. This absence also impacts on the financial sustainability across the hospital. Sickness and absence is monitored and managed at a local level and oversight provided at a weekly Director of Nurse's scrutiny meeting. Programmes of work led by the Heads of Nursing are in place to ensure there are robust processes for monitoring and managing absence in line with Trust policy. This is further supported by programmes of well-being, resilience and self-care for both physical and mental health.

6.2 MRI Safe Staffing

6.2.1 Across MRI wards and departments, **85.2%** of planned Registered Nursing shifts are filled. **Graph 9** shows that on average, 23 of the 24 wards at MRI hospital are achieving more than 80% planned Registered Nurse staffing levels during the night. Priority has been given to ensure the night shifts are adequately staffed when staffing numbers are reduced and less senior cover is available within the hospital. This has resulted in a reduction in day shifts being filled where there are 11 of the 24 wards achieving 80% planned Registered Nurse staffing levels. The lowest fill rate is found within the renal wards where the highest registered nurse vacancies occur. Joint working through the Heads of Nursing has supported redeployment of staff from other areas to support the renal wards as well as daily staffing meetings which ensure clinical areas have appropriate staff on duty.

There is a pipeline of Registered Nurses and Nursing Associates due to commence in post over the next 6 months and to ensure continued patient safety and support the Registered Nursing workforce, these areas have additional Nursing Assistants on duty with a fill rate of 100% during the day in these areas.

Graph 9



6.3 Key Actions

6.3.1 Key work streams have been identified by the Director of Nursing. A reduction in turnover will continue to be a key focus within the MRI for the next 6 months in collaboration with the HR Director. Review of nurses leaving the Hospital has identified that the Emergency Department and Acute Medicine Unit have a higher number of leavers. Work will focus on:-

- Early Years – focus on keeping in touch during recruitment phase, induction and preceptorship
- Career development
- Flexible working
- Retire and return

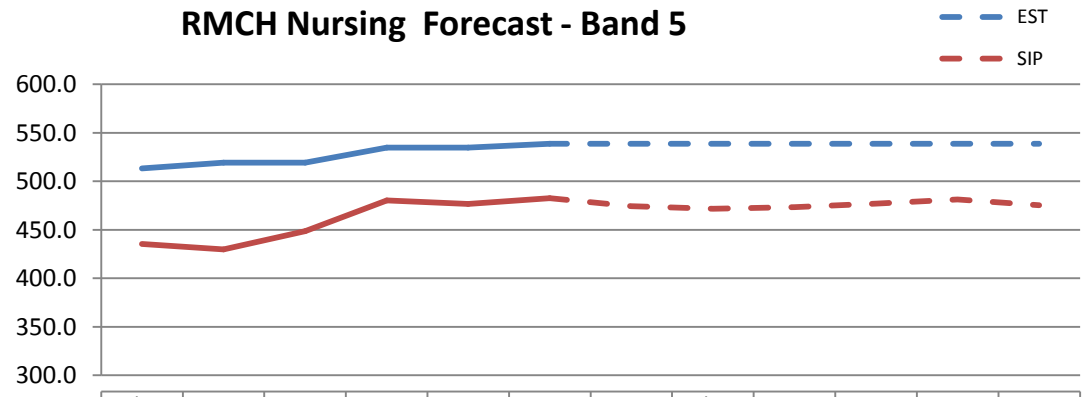
7.0 Royal Manchester Children's Hospital (RMCH)

7.1 RMCH Workforce Position

7.1.1 At the end of December 2018 RMCH had a total of **72.1wte (8.1%)** Registered Nurse vacancies. This is a reduction in overall nursing vacancies of **35wte (2.3%)** since August 2018. The hospital vacancy position is expected to remain static in Q1 when it is predicted there will be **75wte** vacancies **(8.2%).** This will improve in Q3 following the graduation and appointment of newly qualified nurses. These figures represent an improvement on the same period in the previous year and a reduction of **20wte** vacancies **(2.3%)**. It should be noted that the nursing establishment has increased by 30wte since August 2018 due to expansion of the Proton Service. This increase is included in the overall increase in nursing vacancies.

7.1.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 10** illustrates the workforce position in RMCH until June 2019. At the end of December 2018 there were **56.1wte (10.4%)** band 5 nursing vacancies which is a reduction of **33.4wte (7.2%)** vacancies since August 2018. The band 5 vacancy position is expected to remain unchanged in Q1 when it is predicted there will be **63.4wte** vacancies **(11.7%).** This will improve in Q3 following the graduation and appointment of newly qualified nurses.

Graph 10



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	513.4	519.3	519.3	534.8	534.8	538.8	538.8	538.8	538.8	538.8	538.8	538.8
SIP	435.4	429.9	448.7	480.4	476.5	482.6	474.2	471.8	473.5	477.1	481.2	475.3
Vacancies	78.0	89.4	70.6	54.3	58.2	56.1	64.5	66.9	65.2	61.6	57.5	63.4

7.1.3 Paediatric High Dependency Unit (PHDU) is currently the only area within RMCH to have over 20% Registered Nurse vacancies. A total of **37** Registered Nurses are progressing through the recruitment process with 7 nurses recruited and due to commence work on PHDU in March 2019. There are 11 Nursing Associates due to commence in post the next 2 months. A workforce review will be undertaken to introduce the Nursing Associate role into PICU/PHDU.

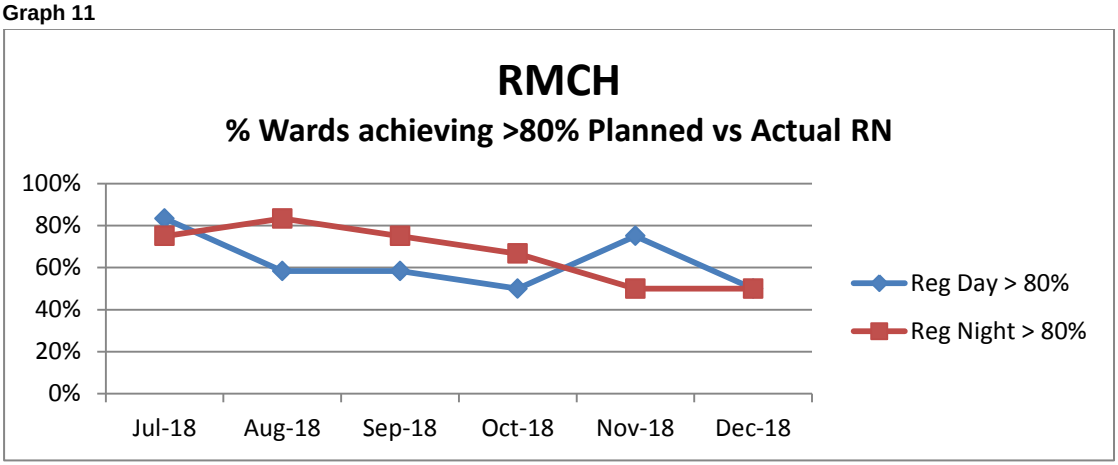
7.1.4 The rolling 12 month turnover for nursing is **11.5%** within RMCH which is below the Trust average and within the Trust target (12.6%). The turnover for Band 5 Staff Nurses is **17.2%** which is higher than the Trust average, however has reduced by 1.2% since August 2018.

7.1.5 Registered Nurse sickness absence levels have increased across RMCH, particularly in November 2018 when it was **5.7%.** Absence is monitored and managed at a local level and oversight provided at the weekly Director of Nursing and Director of Finance Bank and Agency Scrutiny Meeting.

7.2 RMCH Safe Staffing

7.2.1 Across RMCH wards and departments, **82%** of planned RN shifts are filled. **Graph 11** shows 8 of the 12 wards at RMCH are achieving more than 80% planned registered nurse staffing levels during the day and night.

Graph 11



7.3 Key Actions

7.3.1 A number of key work streams have been identified by the Director of Nursing focusing on recruitment and retention of staff to address a reduction in vacancies and turnover and a reduction in the use of bank and agency). A RMCH recruitment and retention strategy and branding will be developed in collaboration with the RMCH HR Director and focus on RMCH's reputation as a leading centre for paediatric care.

8.0 St Mary's Hospital MCS

8.1 SMH MCS Workforce Position

8.1.1 At the end of December 2018, there were a total of **85.6wte (8.1%)** qualified nursing and midwifery vacancies across SMH MCS. This is a reduction in overall nursing and midwifery vacancies of **22.2wte (1.8%)** since August 2018. The Hospital vacancy position is expected to remain unchanged in Q1. This will improve in Q2/3 following the graduation and appointment of newly qualified nurses and midwives.

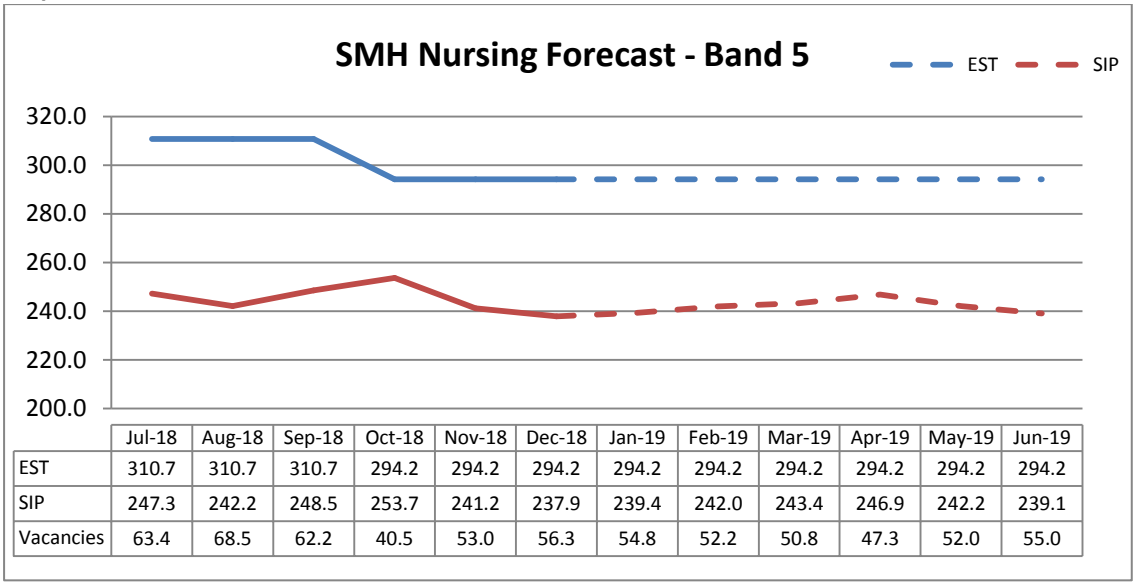
8.1.2 Registered Nursing and Midwifery absence levels have seen a gradual worsening position across SMH MCS, particularly in November 2018 when it was **5.8%.**

8.2 SMH MCS Band 5 Nursing Workforce

8.2.1 The majority of the vacancies within SMH MCS are within the nursing (Staff Nurse Band 5) workforce within SMH**. Graph 12** illustrates the nursing workforce position in SMH until June 2019. At the end of December 2018 there were **56.3wte (19.1%)** Band 5 Staff Nurse vacancies which is a reduction of **12.2wte** (2.9%) since August

2018. The band 5 vacancy position is expected to remain unchanged in Q1. This will improve in Q2/3 following the graduation and appointment of newly qualified Nurses.

Graph 12



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	310.7	310.7	310.7	294.2	294.2	294.2	294.2	294.2	294.2	294.2	294.2	294.2
SIP	247.3	242.2	248.5	253.7	241.2	237.9	239.4	242.0	243.4	246.9	242.2	239.1
Vacancies	63.4	68.5	62.2	40.5	53.0	56.3	54.8	52.2	50.8	47.3	52.0	55.0

8.2.2 The majority of Band Staff Nurse 5 vacancies in SMH occur within the Neonatal Unit (NICU) which is the only department with over 20% Registered Nurse/Midwife vacancies. It should be noted as a result of the expansion of Neonatal cots within Newborn Services there has been an overall increase to the nursing establishment which has in part added to the number of overall vacancies. A total of **19wte** Band 5 Staff Nurses are due to commence employment over the next three months with 14 wte of those within NICU. In recognition of the national shortage of nurses in Newborn Services the Nursing Associate role has been introduced and will be developed to support the service. There are 3 Nursing Associates who have been employed to work on the NICU unit with a plan to recruit more NAs in the future.

8.2.3 The Registered Nursing rolling 12 month turnover is **16.4%** within SMH which is. The turnover rate for band 5 nursing is **22.89%.**

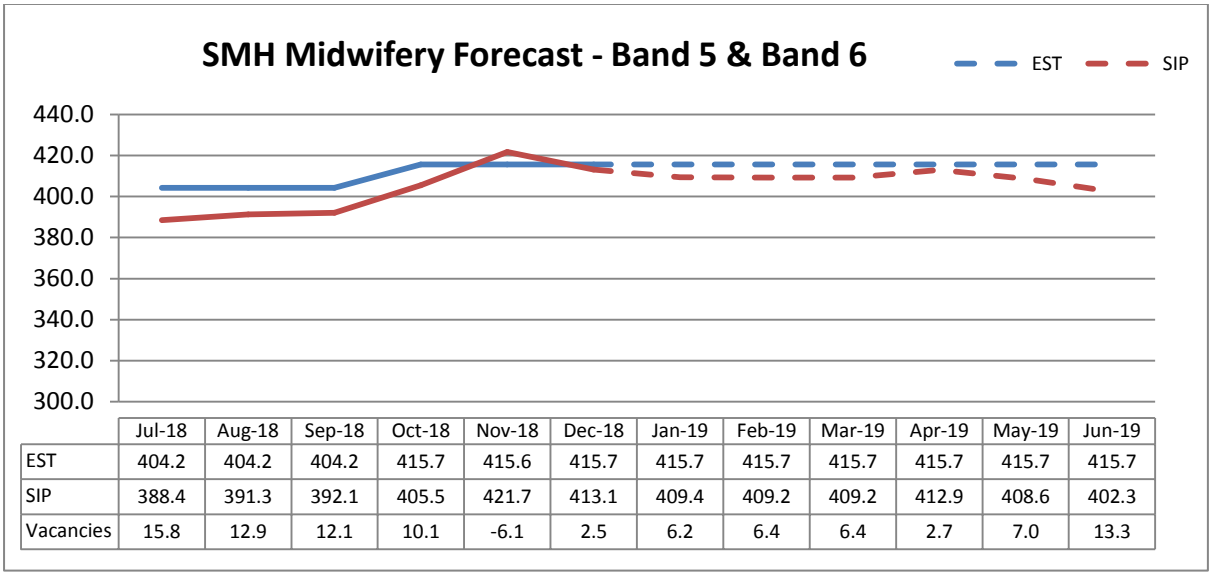
8.3 SMH MCS Band 5 & 6 Midwifery Workforce Position

8.3.1 **Graph 13** illustrates the Midwifery workforce position in SMH MCS until June 2019. At the end of December 2018 there were **2.5wte (0.5%)** band 5 & 6 midwifery vacancies.

8.3.2 The number of midwifery vacancies remains low across maternity services. In January 2019, **6wte** Band 5/6 midwives are due to commence in post, with the next intake of candidates expected in September/ October 2019. It is anticipated that this will cover all existing vacancies at this time.

8.3.3 The overall midwifery rolling 12 month turnover is **10.39%** within SMH which is below the Trust average. The turnover rate for Band 5 and 6 midwives is **11.75%** which is also below the Trust average and Trust target of 12.6%

Graph 13



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	404.2	404.2	404.2	415.7	415.6	415.7	415.7	415.7	415.7	415.7	415.7	415.7
SIP	388.4	391.3	392.1	405.5	421.7	413.1	409.4	409.2	409.2	412.9	408.6	402.3
Vacancies	15.8	12.9	12.1	10.1	-6.1	2.5	6.2	6.4	6.4	2.7	7.0	13.3

8.4 Key Actions

8.4.1 Band 5 and 6 nursing and midwifery retention and turnover is a major focus and the Hospital MCS are developing retention plans to reduce the reliance on temporary staff and improve turnover, working in partnership with the Royal College of Midwives supporting their 'Caring for You Campaign' and continuing to utilise the well-established 'What Matters to Me' programme for all bands of staff.

8.4.2 SMH MCS work closely with the Manchester HEIs to ensure student nurses and midwives are prepared for securing a post on graduation. Planned recruitment days have been arranged in January and May 2019 to attract student nurses and midwives who qualify in June and September 2019. The vacancy position is not expected to improve until September 2019 following the recruitment of graduate nurses and midwives in September 2019.

8.4.3 Newborn Services have acknowledged the challenges to recruit to sufficient staffing levels to encompass the expansion of the increased cot capacity and as such have recently recruited one International nurse. The service is looking to recruit more International Nurses with the appropriate experience in this speciality.

8.4.4 There is a focus on opportunities for career development and where appropriate new roles such as the introduction of the Nursing Associate, enhanced and advanced nursing roles are being embraced across the service and especially in Newborn Services. A nursing and midwifery workforce plan and retention strategy has been developed by the MCS. Investment in staff and their development alongside developing new roles and ways of working will be key to sustainability of the workforce across the MCS Progress against the plan is monitored by the SMH MCS Workforce Committee which is chaired by the Director Nursing/Midwifery.

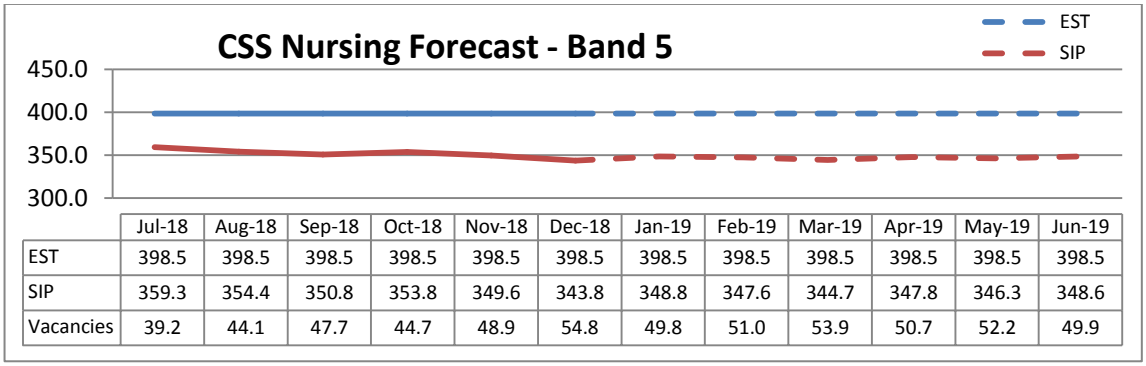
9.0 Clinical Support Services MCS (CSS)

9.1 CSS MCS Workforce Position

9.1.1 At the end of December 2018 there were a total of **90.9wte (14.3%)** qualified nursing vacancies across the CSS Managed Clinical Services. This is an increase in overall nursing vacancies of **19.1wte (2.9%)** since August 2018.

9.1.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 14** illustrates the CSS band 5 workforce position until June 2019. At the end of December 2018 there were **54.8wte (13.7%)** band 5 nursing vacancies (19.36 in CTCCU, 28.8wte within HDU/ICU on Oxford Road Campus). A number of vacant posts have resulted from a recent drive to support flexible working and work life balance, enabling staff to reduce their hours as an alternative to leaving the Trust. This position is expected to improve in Q1 due to the International recruitment pipeline and a series of recruitment events to attract experienced nurses to the critical specialty units.

Graph 14



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5
SIP	359.3	354.4	350.8	353.8	349.6	343.8	348.8	347.6	344.7	347.8	346.3	348.6
Vacancies	39.2	44.1	47.7	44.7	48.9	54.8	49.8	51.0	53.9	50.7	52.2	49.9

9.1.3 There are **16wte** Band 5 Nurses currently going through the recruitment process, with 15 nurses due to commence in post before April 2019. CSS continue to recruit International Nurses through the Trust IR recruitment campaign with an average of 2 nurses starting employment every 6 weeks.

9.1.4 Within CSS MCS the rolling 12 month turnover for nursing is **12.9%.** The band 5 rolling turnover is **16%**, which is an increase of 3% since August 2018.

9.1.5 Whilst there was a reduction in Registered Nursing absence levels over the summer months absence in this staff group has increased to 4.8% during Q3 (was 3.6%). The senior nursing and HR teams have reviewed sickness absence for individual areas and agreed on a number of actions. These include alignment of reporting processes, agreement on absence management procedures, revision and development of HR processes.

9.2 Key Actions

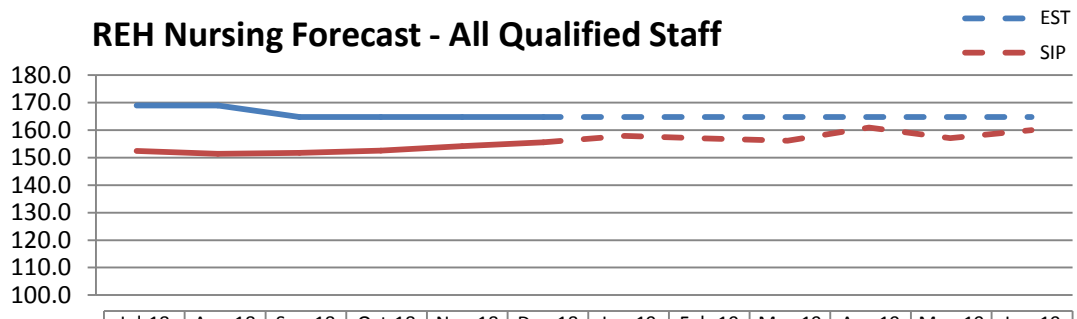
9.2.1 A number of key work streams have been identified by the Director of Healthcare Professions and Deputy Director of Nursing focusing on recruitment and retention of staff to address a reduction in vacancies and turnover.Work will focus on staff satisfaction and wellbeing and this remains one of the key priorities for CSS MCS in the Nursing, Midwifery and AHP Commitments 2018-2021. A number of initiatives are underway including; staff feedback and engagement, recognition schemes, training and development opportunities and a move to 12.5 hour shifts.

10.0 Royal Eye Hospital (REH)

10.1 REH Workforce Position

10.1.1 At the end of August 2018, there were a total of **9.3wte (5.6%)** qualified nursing vacancies across REH as illustrated on **Graph 15**. This is a reduction in the overall nursing vacancies of **6.6wte (4%)** since August 2018. Vacancies remain low in REH and therefore the hospital will continue to recruit to turnover.

Graph 15



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	169.0	169.0	164.8	164.8	164.8	164.8	164.8	164.8	164.8	164.8	164.8	164.8
SIP	152.4	151.4	151.7	152.5	154.2	155.5	157.9	156.9	156.1	160.9	157.0	160.0
Vacancies	16.6	17.6	13.1	12.3	10.6	9.3	6.9	7.9	8.7	3.9	7.8	4.8

10.1.2 Within REH the rolling 12 month turnover for Nursing is **7.7%.** The band 5 rolling turnover is **11%**, which is below both the Trust average and the Trust target of 12.6. The retention of current staff is a high priority for both the Royal Eye and Dental Hospital. The investment in staff and their career development, alongside developing new roles and ways of working in the specialist hospitals is regarded as key to the sustainability of the nursing teams.

10.1.3 Registered Nursing absence levels have fluctuated each month within the REH, with the most recent report highlighting an absence of **6.2%** in November 2018.

10.2 REH Safer Staffing

10.2.1 Within REH, **94.2%** of planned Registered Nurse shifts are filled. Planned and actual staffing data is submitted by ward 55 in REH. The ward consistently achieves more than 80% planned Registered Nurse staffing during both day and night.

10.3 Key Actions

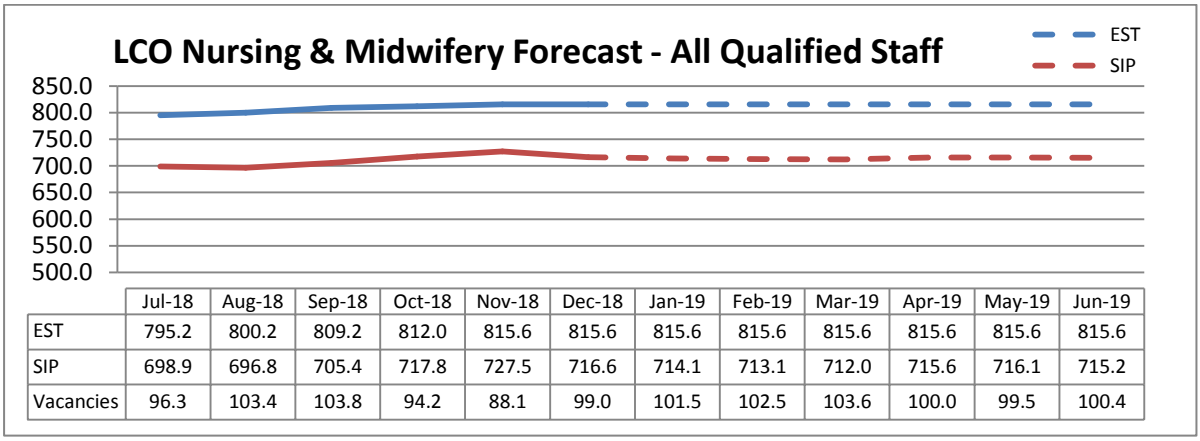
Whilst it is recognised that the turnover of staff and vacancies in REH remains low workforce plans are focusing on the development and retention of staff which is key to supporting specialist services. Recruitment and retention plans are focused on offering opportunities for staff development into specialist nurse roles which provides an attractive offer when recruiting staff.

11.0 Manchester Local Care Organisation (MLCO)

11.1 MLCO Workforce Position

11.1.1 As illustrated in **Graph 16,** at the end of December 2018, there were a total of **99wte (12.1%)** qualified Nursing vacancies across the MLCO a slight increase (**4.8wte)** in overall nursing vacancies since October 2018. The majority of vacancies are within the Staff Nurse (Band 5) workforce. At the end of December 2018 there were **48.8wte (6.1%)** band 5 vacancies.

Graph 16



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
EST	795.2	800.2	809.2	812.0	815.6	815.6	815.6	815.6	815.6	815.6	815.6	815.6
SIP	698.9	696.8	705.4	717.8	727.5	716.6	714.1	713.1	712.0	715.6	716.1	715.2
Vacancies	96.3	103.4	103.8	94.2	88.1	99.0	101.5	102.5	103.6	100.0	99.5	100.4

11.1.2 Recruiting staff to work within some services predominantly Health Visiting (HV), District Nursing and community in-patient facilities, remains a challenge. To ensure the delivery of safe care the HV service has recruited 10 additional nursery nurses to support the gap in HV. For District Nursing and community in-patient facilities future workforce plans have been developed to include the Nursing Associate role of which there are 10 Nursing Associates due to start in the next 3 to 4 months. A business case to support a major recruitment drive for both health and social care positions is being developed. In the meantime the MLCO are working with Group colleagues to

look at international recruitment into intermediate care posts and working with the recruitment service to improve time-to-recruit.

11.1.3 Across the MLCO the rolling 12 month turnover for Nursing is **12.7%.** The band 5 rolling turnover is **11.9%,** which is below both the Trust average and the Trust target of 12.6%.

11.1.4 Registered Nursing sickness absence levels have seen a worsening position across the MLCO, particularly in November 2018 when it was **9.3%.** This poses a further pressure in addition to the vacancy position. A programme of work has commenced to address this supported by a new Human Resource Business Partner.

12.0 Workforce Summary

12.1 Whilst the workforce modelling untaken in this paper has been presented by hospitals and MCSs table 1 provides a summary of the workforce position across the Trust.

Table 1

Hospital/ MCS	RN/RM vacancy wte	RN/RM vacancy %	RN/RM Turnover %	Band 5 vacancy wte	Band 5 vacancy %	Band 5 Turnover %	Fill rate %
Trust	740.7	10.2%	13.2%	554.5	13.9%	16.4%	83.4%
WTWA	192.7	10.6%	12.8%	168.2	16%	16.4%	86.2%
MRI	197.2	12.7%	15.1%	140.5	16.3%	18.8%	85.2%
RMCH	72.1	8.1%	11.5%	56.1	10.4%	17.2%	82%
SMH	85.6	8.1%	12.9%	56.3	19.1%	15.5%	n/a
CSS	90.9	14.3%	12.9%	54.8	13.7%	16%	n/a
REH	9.3	5.6%	7.7%	0	0	11%	94.2%
MLCO	99.0	12.1	12.7%	49.8	6.1	11.9%	n/a

13. Summary

13.1 This paper outlines the continuing challenges in relation to Nursing and Midwifery staffing. Since August 2018 the Trust has experienced an improving Nursing and Midwifery workforce position however, it is recognised that work is still required to reduce the number of nursing and midwifery vacancies. Whilst it is recognised that there are Nursing and Midwifery staffing challenges nationally it is widely accepted that retention of staff must be a key focus on future workforce planning.

13.2 Where appropriate new roles such as the introduction of the Nursing Associate, enhanced, advanced and consultant roles are welcomed by the Trust to improve career opportunities and specifically retention.

13.3 WTWA and MRI have the highest vacancy rates with particular hot spot challenges within general medicine, medical assessment, care of the elderly and orthopaedic surgery. Areas with high vacancies are a priority for recruitment and retention. The opportunity to look to create new roles and ways of working has been presented by developing the role of the Nursing Associate in these areas.

13.4 The Trust works in partnership with NHS Professionals who manage the Trust Bank responding to the Trust temporary staffing demands. This mitigates concerns in relation to safe staffing of the clinical areas and meeting patient care needs. Whilst the number of wards achieving 80% planned staffing levels has reduced since August 2018, measures are in place to maintain patient safety through effective staff redeployment following senior nurse review.

13.5 Across the Trust each Hospital/MCS has established a workforce plan together with a retention strategy. In January 2019 a Retention Workshop was held with the Hospital/MCS Directors of Nursing, Midwifery, HCP and HR to agree a programme of work to improve nursing and midwifery retention. The programme of work will support the following work streams:-

- Career navigation
- Opportunities for Nurses and Midwives to retire and return
- Internal transfer schemes
- Expansion of rotational programmes linking hotspots into areas with low vacancy rates
- Flexible working/Flexible careers
- Building a GM offer in collaboration with other agencies such as transport and housing.
- Develop the Nursing Associate role into speciality areas
- Develop the Operating Department Practitioner (ODP) apprenticeship programme into theatres to support training of ODPs
- Review of support worker roles with focus on development opportunities

13.6 Progress on these work streams will be reported to the Hospital/MCS Management Boards by the Directors of Nursing, Midwifery, HCP and HR. An update on this work will be provided to the HR Scrutiny Committee in June 2019 and the Board of Directors in September 2019.

13.7 The Trust retention programmes are intended to support a sustainable workforce retaining the expertise and experience of Nursing and Midwifery staff and reducing the rate at which staff leave. Investment in these areas will reduce the reliance on the use of bank and agency and support financial sustainability.

14. Conclusion

14.1 The Board of Directors are asked to receive this paper and note progress of the work undertaken to address the Nursing and Midwifery vacancy position across the Group

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney – Group Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse
Date of paper:	January 2019
Subject:	Quarter 3 Complaints Report, Financial Year 2018/19
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Patient & staff Experience
Recommendations	To note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	**Name:** Debra Armstrong – Assistant Chief Nurse **Tel:** 0161 276 5061

Manchester University NHS Foundation Trust (MFT)
Complaints Report 1st October 2018 – 31st December 2018

1. Executive Summary

1.1. Members of the Group Board of Directors are asked to note the Quarter 3, 2018/19 complaints report for Manchester University NHS Foundation Trust, covering the period 1st October 2018 – 31st December 2018.

1.2 This report provides an overview of the Complaints and PALS performance for Quarter 3, 2018/19.

1.4 During Quarter 3, 2018/19, work continued to integrate the Trust's complaints functions and develop a single set of performance metrics. This has enabled comparisons to be made between the Hospitals/Managed Clinical Services (MCS)/ Manchester Local Care Organisation (MLCO) across the Group. An integral part of the integration has involved the reporting alignment of formal complaints and PALS concerns to Hospitals/ MCS and the MLCO for services they manage. Based on this reporting alignment the Quarter 3 report provides more detailed analysis at Hospital/ MCS/ MLCO level than previous reports.

1.5 During Quarter 3, 2018/19 there was a total of 1,497 PALS concerns received. This compares to 1,336 concerns received in Quarter 2; which equates to a 12.1% increase in concerns compared to Quarter 2, 2018/19. Numerically this equates to an increase of 161 PALS concerns.

1.6 During Quarter 3, Quarter 3, 2018/19, there were a total of 343 new formal complaints received. This compares to 403 new formal complaints received in quarter 2; which equates to a 14.9% decrease in formal complaints compared to Quarter 2, 2018/19.Numerically this equates to a decrease of 60 formal complaints. There continues to be a natural seasonal variation of complaint numbers at Group level and the Assistant Chief Nurse continues to monitor the variation closely.

1.7 The largest numerical increases in the number of complaints received this period were within Clinical Sciences Services (CSS) with an increase of 8 (47.1%) and the MLCO with an increase of 8 (200%). The largest decrease in the number of complaints received was at Manchester Royal Infirmary (MRI), with a reduction of 31 (26.1%) in Quarter 3, 2018/19 compared to the number of complaints received in Quarter 2 (2018/19). Additional support has continued to be provided to MRI from the corporate team during Quarter 3, 2018/19.

1.8 The total number of complaints closed in Quarter 3, 2018/19 was 449, an increase (positive) of 3 cases compared to 446 in Quarter 2, 2018/19.

1.9 During Quarter 3, 2018/19 there was a notable decrease (positive) in the number of complaint responses, resolved at over 41 days, compared to the number of complaint responses resolved at over 41 days in Quarter 2 (2018/19), which reflects in a 8.3% (positive) reduction of 36 cases.

1.10 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days after the complaint is received. The Trust achieved 99.5% compliance with this Key Performance Indicator during Quarter 3, 2018/19. The one acknowledgement breach was due to human error at the triage stage of the formal complaint process.

1.11 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Quarter 3, 2018/19. The Specialist Medicine (SMS) and Surgery Divisions from MRI and Royal Manchester Children's Hospital (RMCH) each presented a case at the November 2018 meeting. The learning identified from the cases presented is detailed in Section 5 of this report.

1.12 Improvements in the Complaint and PALS management processes are described in the report (Section 9) with future quality improvements identified.

1.13 The Group Quality and Performance Scrutiny Committee supported a recommendation from the Chief Nurse that Hospitals/MCS and MLCO teams manage all compliments at a local level and formal compliments are removed as a group-level quality indicator (Section 2) as they do not provide the Board of Directors with assurance in regards to the quality of services. There are a number of other key metrics considered by the Board which provide assurance on the quality of services.

1.14 The Group Board of Directors is asked to note the information within the report and the ongoing integration and development of the complaints system during Quarter 3, 2018/19.

2. Overview of Quarter 3 Performance

PALS

2.1 During Quarter 3, 2018/19 there was an increase in PALS concerns with 1,497 PALS concerns being received, compared to 1,336 in Quarter 2. This equates to a 12.1% increase in concerns compared to Quarter 2, 2018/19 and is numerically an increase of 161 PALS concerns.

2.2 As appropriate and in agreement with the complainant, PALS concerns can be escalated to formal complaints or formal complaints de-escalated to PALS concerns. The number of cases escalated and de-escalated has been collated across all Hospitals/ MCS and the MLCO since 01st April 2018 as an integral part of the implementation of the new Trust Ulysses Complaint Module.

2.3 There were 8 PALS cases escalated for formal investigation during Quarter 3, this is a reduction when compared to the 14 PALS cases escalated during Quarter 2, 2018/19. Cases are predominantly escalated due to the complexity of the complaint received and following discussion and agreement with the complainant advising that formal investigation should be undertaken.

2.4 Conversely 11 formal complaint cases were de-escalated during Quarter 3, 2018/19; this compares to 7 cases de-escalated during Quarter 2, 2018/19.

2.5 The Hospitals/MCSs with the highest number of PALS concerns during Quarter 3, 2018/19 was Wythenshawe, Trafford, Withington and Altrincham (WTWA) with 515 cases (34.4%), followed by MRI with 402 cases (26.9%) of the PALS cases received. A detailed analysis of the PALS concerns for Quarter 3 for WTWA has identified the most common area for concern is Outpatient Appointment delay/ cancellation. The analysis has been shared with the Director of Nursing for WTWA.

2.6 The majority of PALS concerns during Quarter 3, 2018/19 related to Outpatient areas, which accounted for 1,129 (75.4%) of the 1,497 contacts received. This compares to 950 (71.1%) of concerns raised during Quarter 2, 2018/19 relating to the Outpatient areas.

2.7 **Table 1** shows the timeframes in which PALS concerns have been resolved during the previous four quarters.

Table 1: Closure of PALS concerns within timeframes.

	Quarter 4, 2017/18		**Quarter 1, 2018/19**		**Quarter 2, 2018/19**		**Quarter 3, 2018/19**	
Days to Close	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe
0-7	1075	74.6%	922	76.3%	126	72.0%	1181	77.0%
8-14	292	20.3%	247	20.4%	313	23.0%	325	21.2%
15+	74	5.1%	40	3.3%	63	5.0%	27	1.8%

2.8 In Quarter 3, 2018/19 the number of cases taking longer than 14 days to close decreased significantly from 63 (5.0%) in Quarter 2 to 27 (1.8%) of all cases. At the beginning of Quarter 2, 2018/19 a new process was implemented for the escalation of all PALS cases over 12 days. All cases are now escalated to the PALS Manager on day 12 and this earlier escalation process has been successful in reducing the time to resolve PALS concerns.

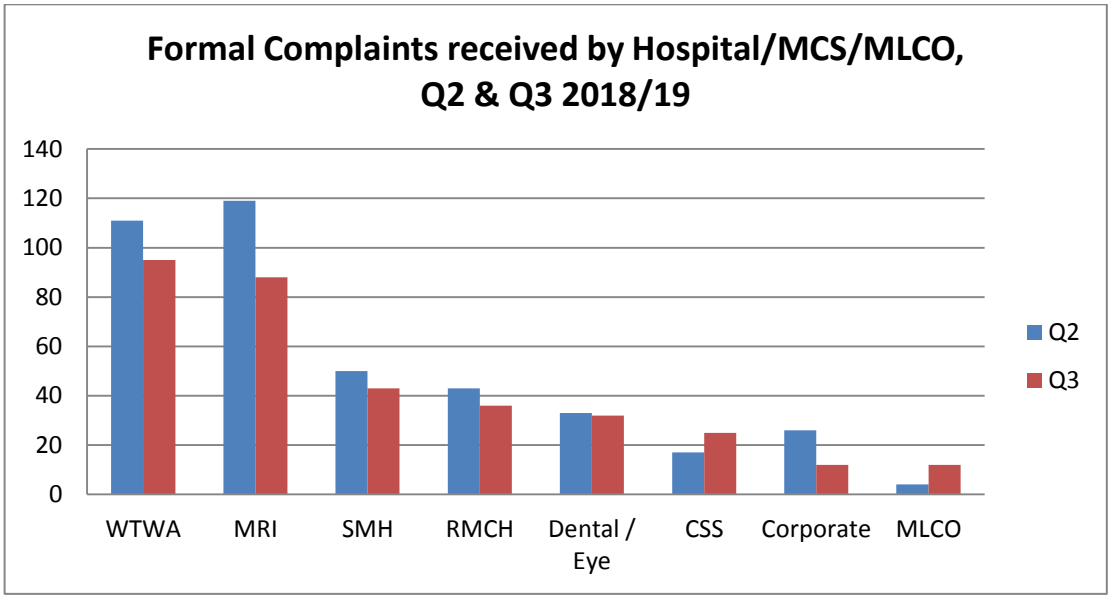
New Formal Complaints

2.9 The Group Board of Directors Complaint Reports for previous Quarters 1 and 2, 2018/19, outlined the changes in reporting as complaints were reallocated to MCS. This has resulted in an increase in the number of complaints recorded by CSS, RMCH, Saint Mary's Hospital (SMH) and Corporate Services as formal complaints from all hospital sites are now aligned to these MCS. This has conversely resulted in an on-going reduction of formal complaints assigned to WTWA.

2.10 During Quarter 3, 2018/19, there were a total of 343 new formal complaints received. This compares to 403 received in Quarter 2, 2018/19 and 461 received in Quarter 1, 2018/19. This represents a 14.9% decrease in formal complaints (decrease of 60 in number) when compared to Quarter 2, 2018/19. There continues to be a natural seasonal variation of complaint numbers at Group level and the Assistant Chief Nurse continues to monitor the variation closely. Work is underway in Quarter 4 to report this variation by Hospital/ MCS and MLCO to allow proactive management by the Hospital/ MLCO and MLCO senior teams based on expected volumes of complaints, whilst improvement programmes are underway to reduce the number of complaints.

2.11 **Graph 1** compares the total number of new formal complaints received by Hospital/MCS and the MLCO in Quarter 2 and Quarter 3, 2018/19.

Graph 1: Total number of Formal Complaints Received by Hospital/MCS and the MLCO.



2.12 During Quarter 3, 2018/19 WTWA received the most complaints (95) however this was an overall decrease of 8 cases compared to Quarter 2, 2018/19. The largest decrease in the number of complaints received from Quarter 2 to Quarter 3, 2018/19 was at MRI which had a reduction of 31 cases (26.1%). The MRI continues to be supported by the Corporate Nursing team

2.13 CSS had an increase of 8 (47.1%) complaints received in Quarter 3, 2018/19 and the MLCO had an increase of 8 (200%). It is important to note that where a relatively small number of complaints are received, large percentage variations can be caused by relatively small numerical fluctuations hence the numerical figures are also reported.

2.14 During Quarter 3, 2018/19, there were 110 new complaints made relating to inpatient services and 155 relating to outpatient services. For inpatient services, this represents a decrease of 30 cases (21.4%) compared to Quarter 2, 2018/19 and for outpatient services, this represents a decrease of 23 cases (12.9%) compared to Quarter 2, 2018/19. The area with the highest number of outpatient complaints for Quarter 3, 2018/19 was MRI with a total of 37 of the 155 total (23.8%). Themes identified for inpatient services were general medical care and communication failure with patient/relative and themes for outpatient services were appointment delay and treatment/procedure delay/failure.

2.15 The national statutory requirement for the acknowledgement stage of formal complaints handling, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. The Trust achieved 99.5% compliance with this key performance indicator (KPI) during Quarter 3, 2018/19 compared to 100% both in Quarter 1 and 2, 2018/19. The one acknowledgement breach was due to human error at the triage stage of the formal complaint process. To minimise the risk of the error recurring a revised Triage process has been developed to ensure new complaints are acknowledged by the second day following receipt.

Current Complaints

2.16 In accordance with the NHS Complaint Regulations (2009) the Trust has identified complaint response timescales as; 25 working days, 26-40 working days and 41 days and above. The performance against these timescales is monitored.

2.17 In accordance with the Trust's Complaint Triage process timescales are discussed and agreed with the complainant in 3 broad timeframes, as follows:

- 25 working days, normal response timeframe
- 40 working days, highly complex case response timeframe
- 60 workings days, highly complies case involving multiple organisations, High Level Investigations (HLIs), Independent/External reviews and HR investigations response timeframe

2.18 The accountability for complaints management and monitoring has been fully devolved to the Hospital/MCS and the MLCO Chief Executives and since Quarter 1, 2018/19 and performance is monitored at a Group level via the AOF.

2.19 At the end of Quarter 3, 2018/19 there was 217 open formal complaints compared to 284 unresolved at the end of Quarter 2, 2018/19. This is a 23.6% decrease (positive) at the end of Quarter 3, compared to the end of Quarter 2; equating to 67 fewer open complaints. The open complaints comprised 117 which had been registered between 0-25 days, 54 between 26-40 days, (45 of which were in planned and agreed timescale with the complainant) and 46 had been registered for 41 or more days, (35 of which were in planned and agree timescale with the complainant).

2.20 There were 46 cases unresolved at 41 or more days at the end of Quarter 3, 2018/19 compared to 76 complaints at the end of Quarter 2, 2018/19. This represents a 39.5% decrease in over 41 day cases from Quarter 2 to Quarter 3, 2018/19.

2.21 MRI had the highest number of open cases at the end of Quarter 3, 2018/19 with 79 open cases (47 of which were in planned timescale) compared to 98 open cases in Quarter 2, 2018/19 and 113 open cases in Quarter 1, demonstrating significant improvement. Of the cases open at the end of Quarter 3, 35 were within 0-25 days,, 27 were within 26-40 days (24 of which were in planned and agreed timescale) and 17 were over 41 days (10 of which were in planned and agreed timescale).

Resolved Complaints

2.22 The oldest complaint case closed during Quarter 3, 2018/19 was registered at WTWA (Trafford) on 27th December 2017 and was 223 days old when closed on 13th November 2018. Delays in receiving the clinician's comments and legal quality assurance unfortunately resulted in the exceptional delay and Trust not being in a position to provide a timely response. The complainant was kept updated throughout the process.

2.23 **Table 2** provides a comparison of formal complaints resolved within each timeframe from Quarter 4, 2017/18 to Quarter 3, 2018/19.

Table 2: Comparison of formal complaints resolved by timeframe

	Quarter 4 2017/18	Quarter 1 2018/19	Quarter 2 2018/19	Quarter 3 2018/19
Formal Complaints Resolved	295	541	446	449
Resolved in 0 25 days	78 (26.4%)	136 (25.1)%	160 (35.9%)	161 (35.9%)
Resolved in 26 - 40 days	88 (29.8%)	76 (14.0%)	94 (21.1%)	132 (29.4%)
Resolved in 41+ days	129 (43.7%)	329 (61.0%)	192 (43.0%)	156 (34.7%)

2.24 The number of cases resolved within 0-25 working days in Quarter 3 was comparable to Quarter 2, 2018/19. Between Quarter 2 2018/19 and Quarter 3, 2018/19 there was an increase of 38 cases resolved between 26-40 days; there was a significant decrease (positive) in the number of cases resolved at 41+ days by 36 cases.

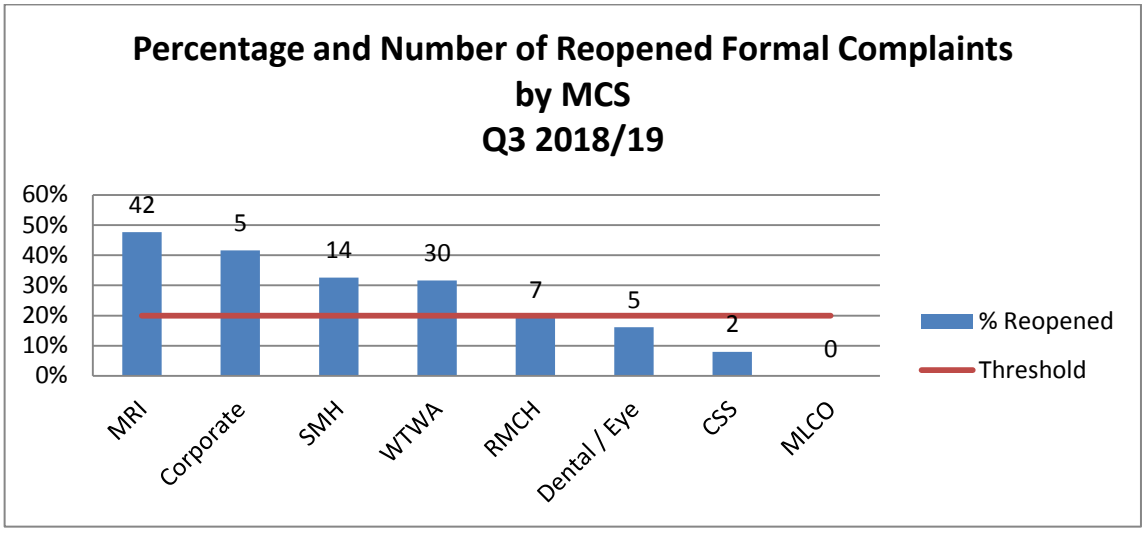
Reopened Complaints

2.25 Re-opened formal complaints are used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed by the Group Chief Nurse. The number of re-opened complaints received in Quarter 3 was comparable with Quarter 2, 2018/19, however due to the decrease in the number of new complaints received in Quarter 3, the percentage of re-opened complaints received increased (negative) to 30.6% of all complaints received, compared to 20.8% in Quarter 2, 2018/19.

2.26 The highest number of re-opened cases was received by MRI in Quarter 3, 2018/19. Of the 42 re-opened cases received by MRI the cases were predominantly reopened due to unresolved issues.

2.27 **Graph 2** illustrates Hospital/MCS and the MLCO performance against this threshold in Quarter 3, 2018/19; MRI 47.7% (42 re-opened cases), Corporate Services 41.7% (5 re-opened cases), SMH 32.6% (14 re-opened cases), WTWA 31.6% (30 re-opened cases) exceeded the 20% threshold during Quarter 3, 2018/19; with all the other Hospitals/MCS and the MLCO recording re-opened cases below the threshold. It should be noted, however, that small fluctuations in the total number of complaints received in a Hospital/MCS or the MLCO can result in large percentage changes for those areas with overall low number of complaints. Complaint management training is being offered to all Hospital/MCS and the MLCO teams focused on the quality of complaint responses as part of the educational sessions as detailed in Section 9.2.2 of this report.

Graph 2: Percentage of re-opened Formal Complaints (Quarter 3, 2018/19).



Trust-Wide Compliments

2.28 The registration of written compliments received by the Group Chief Executive is managed by the PALS Team and the Hospital/MCS/MLCO management teams manage registration of locally received compliments on the Ulysses Complaint Module. All responses are managed locally by the Hospitals/ MCS/ MLCO. There is recognition that there are many other methods that patients, families and carers utilise to provide feedback about the satisfaction and quality of care received, these include but are not exclusive to thank you cards, tweets, face book postings and gifts. This feedback is not captured, formally recorded or reported. The indicator may actually perversely make departments look like services are deteriorating because they have no received written formal compliments but have received informal compliments from other sources such twitter, Facebook, cards and gifts. Measuring only written compliments that are received consequently does not adequately represent the number of compliments received by the organisation.

2.30 The Group Quality and Performance Scrutiny Committee has recently supported a recommendation from the Chief Nurse that Hospitals/MCS and MLCO teams manage all compliments at a local level and compliments are removed as a group-level quality indicator.

3. Care Opinion and NHS Website feedback

3.1 Care Opinion and the NHS Website are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services.

3.2 The number of Care Opinion and NHS Website comments by category; positive, negative and mixed positive and negative comments are detailed in **Table 3.**

3.3 The Care Opinion and NHS Website feedback demonstrates that half of the overall comments (50%) received in Quarter 3, 2018/19 were positive. This represents a reduction compared to Quarter 2, 2018/2019 when the overall positive comments represented 67.7% of the total. Negative comments equate to 41.1% of the overall total received during Quarter 3, 2018/19, which reflects a 24.2% increase when compared to 16.9% during Quarter 2, 2018/19. There is currently no specific identifiable reason for this change, which will be monitored to identify whether this is an isolated result or develops into a trend.

3.4 The increase of negative comments received related to MRI and WTWA, with MRI receiving a total of 7 negative comments in Quarter 3, 2018/19 compared to 1 in Quarter 2, 2018/19 and WTWA receiving a total of 11 negative comments in Quarter 3, 2018/19 compared to 5 in Quarter 2, 2018/19. The Hospitals/MCS/MLCO's receive all the posted comments and provide responses and offer the person posting the comment to make contact with PALS should they require a level of support or investigation to ensure the service has opportunity to make improvements of the feedback.

3.5 All Care Opinion and NHS Website comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/MLCO, requesting a response for publication with 5 working days. Within each Hospital/MCS/MLCO designated staff support the provision of a response to the Patient Experience Team, who ensure responses are quality assured, either by the Hospital/MCS/MLCO or Corporate Team prior to posting on line.

Table 3: Number of Care Opinion/NHS postings by Hospital/MCS/MLCO in Quarter 3, 2018/19.

Number of Postings received by Hospital/ MCS/ Division Quarter 3, 2018/19			
Hospital/ Managed Clinical Service (MCS)	**Positive**	**Negative**	**Mixed**
Manchester Royal Infirmary	**5**	**7**	**1**
Wythenshawe, Trafford, Withington and Altrincham	**15**	**11**	**3**
Clinical Scientific Services	**0**	**0**	**1**
Corporate Services (Estates and Facilities)	**0**	**0**	**0**
Manchester Royal Eye Hospital / University Dental Hospital of Manchester	**5**	**2**	**0**
Royal Manchester Children's Hospital	**1**	**1**	**0**
St Marys Hospital	**2**	**2**	**0**
Overall MFT Total	**28**	**23**	**5**

3.6 **Table 4** provides two examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Quarter 3, 2018/19.

Table 4: Example Care Opinion/ NHS Website Postings and Reponses.

Quarter 3 , 2018/2019
Accident and Emergency Services, Manchester Royal Infirmary at 04/11/2018 End of life care and memorial service at the hospital.
In March this year my father passed away from pneumonia. The treatment, care and support shown by the doctors and nurses was outstanding. They treated him with respect and dignity, as well as supporting us as a family. Thank you. In October, we were invited to a memorial service which was held in the chapel. It was a beautiful service, which my mum and the rest of the family truly appreciated. We'd really like to thank all those involved for doing something so unexpected and thoughtful.
Response
Please accept our condolences on the loss of your father and thank you for your kind comments regarding the treatment, care and support given to your father and family by our staff. We are pleased to note that you felt your father was treated with dignity and respect and that your family were supported at a difficult time. We are also pleased that you and your family had the opportunity to attend the memorial service provided by our Chaplaincy and Spiritual Care Team. Please be assured that your feedback will be shared with our staff members both within the hospital and the Multi Faith Centre.
Haematology at Trafford General Hospital a rating of 3 stars
Can we please make appointments I went for a blood test last week. The Phlebotomy staff are always great and there is no complaint there but have to have a blood test every month and as I work full time it is becoming impossible to avoid it interfering with my job. The last few times I have queued for nearly 2hours. I've tried a variety of times to no avail. It used to be quiet in the afternoon but not for over a year now. Could we please have some kind of appointment/ booking system to avoid these incredibly long way times? Thank you.
Response
Thank you for your comments posted on the NHS website. We are sorry to learn of the delay you experienced whilst waiting for a blood test at Trafford General Hospital and for the inconvenience and frustration this caused you. It is important to us that comments are heard and seen as an opportunity provided to the service to make changes and improvements wherever possible. In response to your comment, we are pleased to inform you that all blood tests in Trafford will be by appointment only from the 1st November 2018. It is hoped that introducing a booking system for our Trafford patients for blood tests will reduce the amount of waiting time in phlebotomy clinics and improve patient experience. Please be assured that we take all issues surrounding patient care very seriously. If you wish to discuss your concern regarding the phlebotomy services at Trafford General Hospital further please contact our Patient Advice and Liaison Service on0161 276 8686 or email pals@mft.nhs.uk and they will be happy to discuss this with you.

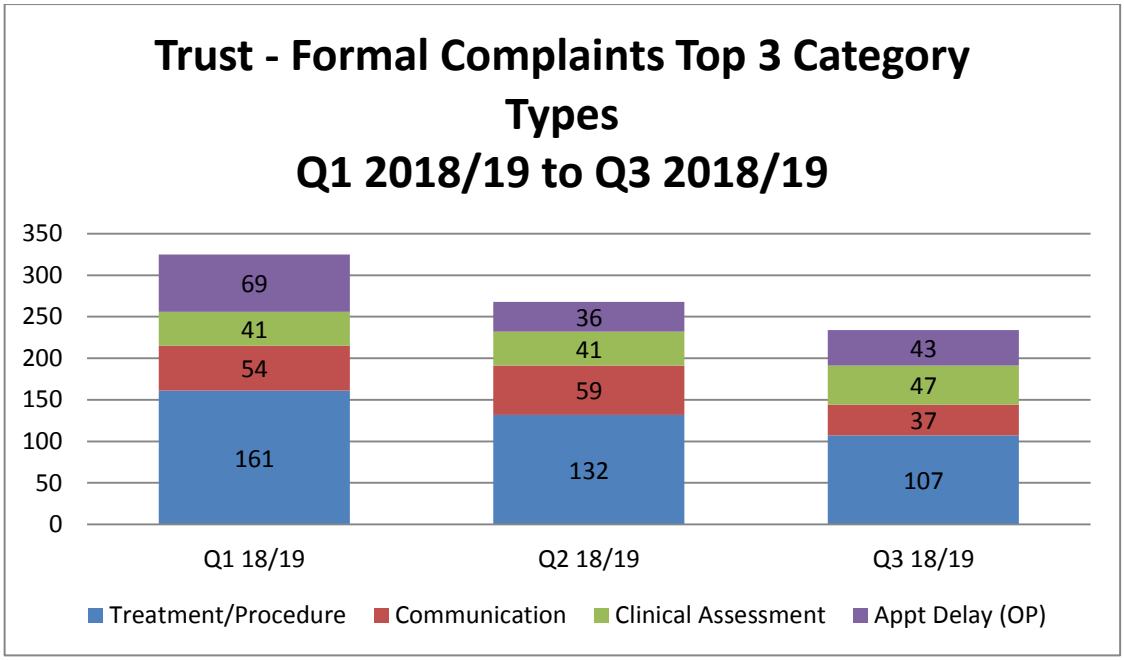
4. Top Themes from Complaints and PALS contacts

4.1 In Quarter 3, 2018/19 the medical staffing group were cited in 45.0% of all PALS contacts, compared to 38.5% in Quarter 2, 2018/19. This staff group were also cited in 53.3% of formal complaints in Quarter 3, compared to 45.0% in Quarter 2, 2018/19. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff it is recognised that medical staff as the lead practitioner for episodes of care in outpatients consultations will undertake the majority of the face to face interactions therefore are more likely to be cited by patients who wish to make a complaint. Actions in relation to this trend are undertaken on a case by case basis by the relevant Hospital/MCS and the MLCO. In addition, the Head of Customer Services provides educational input with regard to customer service and complaints management on the New Consultants Programme.

4.2 The top three category types for formal complaints from Quarter 1, 2018/19 to Quarter 3, 2018/19 are shown in **Graph 3.**

4.3 'Treatment/Procedure' and 'Clinical Assessment' remain in the top three categories; however, in Quarter 3, 2018/19 'Appointment, delay/cancellation (OP)' is the third category replacing 'Communication' which was in the top 3 categories in the previous three quarters.

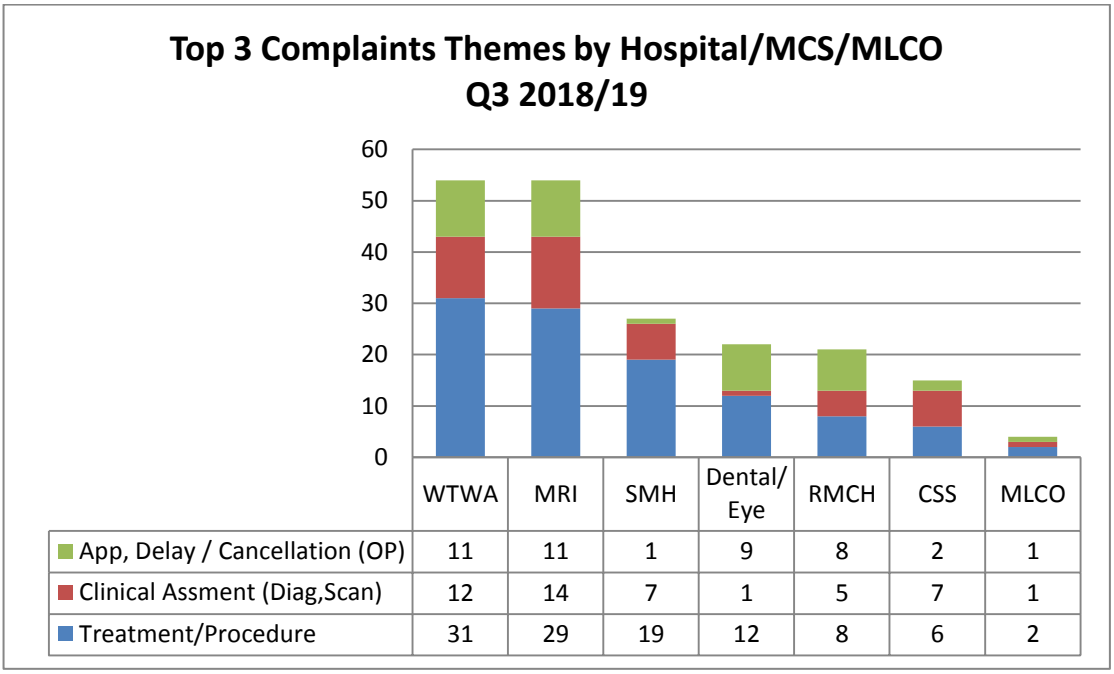
Graph 3: Formal Complaints – Top 3 Categories Quarter 3, 2018/19, Quarter 2, 2018/19, Quarter 1, 2018/19.



4.4 **Graph 4** illustrates the total number of top 3 categories by Hospital/MCS and the MLCO in Quarter 3, 2018/19.

4.5 In Quarter 3, 2018/19 the top category, 'Treatment/Procedure' (107) cited in 28.9% of WTWA's formal complaints and 27.1% of MRI formal complaints. In addition, 'Treatment/Procedure' accounted for 70% of SMH's formal complaints.

Graph 4: Total number of Top 3 Categories by Hospital/MCS/MLCO



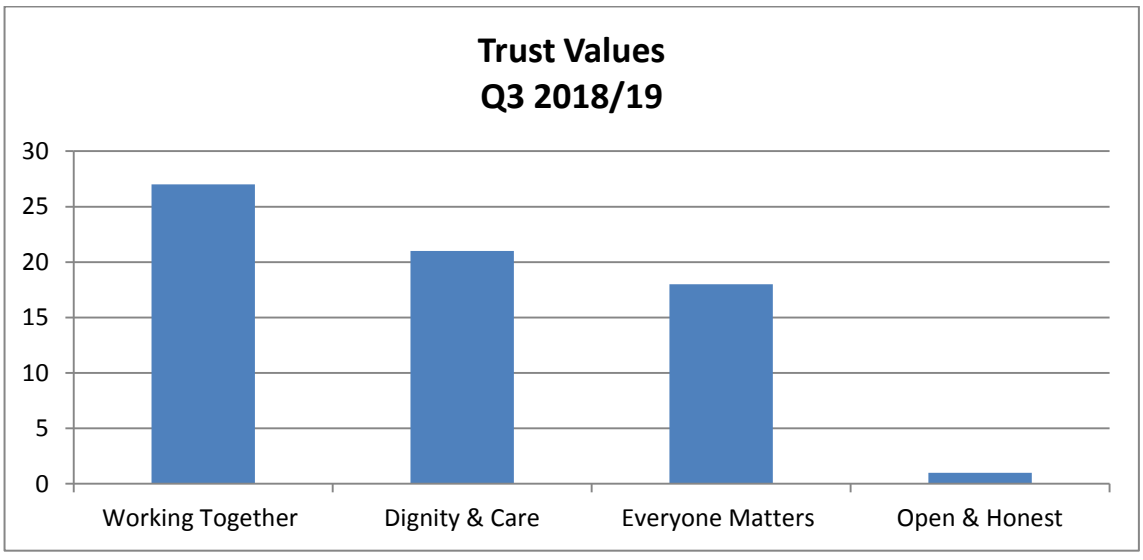
	WTWA	MRI	SMH	Dental/ Eye	RMCH	CSS	MLCO
App, Delay / Cancellation (OP)	11	11	1	9	8	2	1
Clinical Assment (Diag,Scan)	12	14	7	1	5	7	1
Treatment/Procedure	31	29	19	12	8	6	2

Theming Complaints

Following implementation of the new Ulysses Complaints Module for MFT in Quarter 1, 2018/19, work is on-going to theme the concerns raised in complaints to the new MFT Trust Values; ***Everyone Matters, Working Together, Dignity & Care & Open and Honest.***

The Trust-wide themes from the concerns identified in complaints compared to the MFT Trust Values from Quarter 3, 2018/19 are shown in **Graph 5**. This is the first time this information has been reported. As more data is available this will provide an opportunity to further understand the adoption and impact of Trust Values at both a group and Hospital/ MCS/ MLCO level, with the expectation that the number of concerns raised about the values not being adopted will reduce.

Graph 5: Formal Complaints – Theming of complaints to MFT Trust Values for Quarter 3, 2018/19



Due to the diversity of complaints received only 67 of the 343 new formal complaints received in Quarter 3, 2018/19, contained concerns which did not align with the MFT Trust Values.

5. Complaints Scrutiny Group

5.1 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Quarter 3, 2018/19. The Specialist Medicine (SMS) and Surgery Divisions from MRI and RMCH each presented a case at the November 2018 meeting.

5.2 The learning identified from the cases presented and the actions discussed and agreed at the meeting are outlined in **Table 5**. Transferable learning from complaints is identified and shared through this group.

Table 5: Actions identified at the Trust Complaints Scrutiny Group during Quarter 3, 2018/19

Division/ Hospital	Learning	Actions
MRI (SMS)	Need for reasonable adjustments - 'Open' visiting for vulnerable patients	▪ Policy reiterated to all staff in Manchester Heart Centre regards 'open' visiting & reasonable adjustments
	Ineffective communication	▪ Complaint shared with ward and medical staff highlighting the importance of accuracy and timeliness of communication
MRI (Surgery)	Receipt of compliment not registered	▪ Compliment to be registered on Customer Services database
	Poor communication regarding waiting times	▪ Consideration to be given as to how correct waiting times for surgery can be provided to patients to ensure appropriate expectations are set and waiting times understood ▪ Complaint to be shared at December 2018 ACE Day ▪ Follow up process (following inpatient discharge) to be reviewed ▪ Review of use of Stoma Nurse input

RMCH	Actions not captured as part of the complaints process	▪ Share complaint with team to ensure learning ▪ Establishment of RMCH quality assurance (QA) process ▪ Re-establishment of Hospital/Clinical Service Unit weekly position report ▪ Implementation of weekly KPI meeting ▪ Complaints responses to clearly identify action points ▪ Increased focus on learning from complaints rather than the process ▪ Quarterly update to RMCH Safety & Quality Committee for learning
	Lead clinician to coordinate patient pathway	▪ Review Manchester Access Group in Children (MAGIC) service and hours of working ▪ Look into how can be linked in with Complex Care Project

6. Parliamentary and Health Service Ombudsman (PHSO)

6.1 The PHSO makes the final decisions on complaints that have not been resolved by the NHS in England, UK government departments and other public organisations.

6.2 The Trust had 15 cases under the review of the Parliamentary and Health Service Ombudsman at the end of Quarter 3, 2018/19 compared to 28 under review at the end of Quarter 2, 2018/19. **Table 6** provides details of the progress of each PHSO case, specifically the number of reports that are awaited and shows the distribution of PHSO cases across the Hospitals/MCSs.

Table 6: Overview of PHSO Cases open as at 31st December 2018

Hospital/MCS Division	Case	PHSO Investigation Progress	
Corporate	1	Investigations on-going:	Awaiting final report (1 case)
Dental	1	Investigations on-going:	Awaiting final report (1 case)
MRI (SMS)	2	Investigations on-going:	Awaiting final report (1 case) Proposal to investigate (1 case)
MRI (Surgery)	4	Investigation on-going:	Awaiting draft report (2 cases) Awaiting final report (1 case) Proposal to investigate (1 case)
RMCH	2	Investigation on-going:	Awaiting draft report (2 cases)
WTWA	6	Investigations on-going:	Awaiting draft report (4 cases) Awaiting final report (1 cases) Proposal to investigate (1 case)
Total	**16***		

*Please note the total number of cases (16) displayed in **Table 6** is higher than the 15 cases under review as one of the PHSO ongoing cases involved two of the Hospitals/MCS.

6.3 The PHSO closed 18 cases in Quarter 3, 2018/19; of these cases 8 cases were not upheld, 9 cases were partially upheld and 1 case was upheld.

6.4 The Trust were asked to pay financial redress of £2,450 in Quarter 3, 2018/19, compared to no financial redress in Quarter 2, 2018/19 and £100 in Quarter 1, 2018/19. The complaints to which the financial redress related to were related to care received before the formation of MFT.

6.5 The PHSO recommended 65 complainants received pay-outs in Q1 2018/19 totalling £46,533 paid out. The MFT financial redress represents 0.2% of the NHS organisations the PHSO investigated in Q1 which represents a small financial claim given the size of the Trust.

Table 7: PHSO closed cases in Quarter 3, 2018/19 presented by outcome.

Division/ Hospital	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
MRI (Surgery)	Upheld	13/02/17	Failings in care and treatment	Written formal apology and financial redress in the sum of £1,000
MRI (Surgery/ DMACS/SMS) + CSS	Partly upheld	15/07/16	Failings in care and treatment	Written formal apology and action plan outlining lessons learnt
MRI (Surgery) + CSS	Partly upheld	10/12/15	Failings in care and treatment	Written formal apology and action plan outlining lessons learnt
MRI (DMACS) + CSS	Not upheld	08/01/18	No failings found	None
MRI (DMACS) + CSS	Partly upheld	21/04/17	Failings in care, treatment and communication	Written formal apology and action plan outlining lessons learnt
MRI (DMACS)	Not upheld	23/11/17	No failings found	None
MRI (DMACS/SMS)	Partly upheld	12/04/16	Failings in care, treatment and communication	Written formal apology and action plan outlining lessons learnt. Financial redress in the sum of £500
RMCH	Not upheld	01/06/17	No failings found	None
SMH	Not upheld	09/05/16	No failings found	None
SMH + CSS	Not upheld	08/06/17	No failings found	None
University Dental Hospital of Manchester (UDHM)	Not upheld	15/12/16	No failings found	None

UDHM	Partly upheld	20/10/17	Failing to arrange a scan which would have resulted in earlier treatment	Financial redress in the sum of £350
UDHM	Partly upheld	26/10/17	Failings in care	Written formal apology and financial redress in the sum of £350
WTWA (Wythenshawe) + CSS	Partly upheld	28/12/13	Failings in care, treatment and communication	Financial redress in the sum of £250
WTWA (Wythenshawe)	Not upheld	22/07/15	No failings found	None
WTWA (Wythenshawe) + MRI (SMS)	Partly upheld	09/02/16	Drug error identified	Written formal apology
WTWA (Wythenshawe - Medicine)	Partly upheld	31/01/17	Failure to observe during triage	Written formal apology
WTWA (Wythenshawe - Surgery)	Not upheld	05/09/17	No failings found	None

6.6 In December 2018, the PHSO published **'Complaints about the NHS in England (Quarter 2 – 2018/2019)'**. The report presents data on complaints about the NHS in England from July to September 2018 (Quarter 1, 2018/19). It presents national data about the NHS complaints received, assessed and investigated by the PHSO, as well as the recommendations made to Trusts during this period.

When the PHSO identifies failings, they make recommendations to organisations to put things right. Each case can have more than one recommendation. **Table 8** provides a summary of the recommendations made by PHSO nationally to NHS organisations in Quarter 2, 2018/19, alongside the recommendations they made to MFT in the same period.

Table 8: National PHSO Recommendations and MFT Recommendations, Quarter 2, 2018/19

Recommendation	**Total PHSO Q1, 2018/19 recommendations**	**MFT recommendations from PHSO investigations, Q1, 2018/19**
Formal Apologies	118 complaints	3 complaints (partially upheld)
Payments	65 complaints involved payments to make up for financial loss or to recognise the impact of what went wrong. This totalled £46,533 from the NHS organisations the PHSO investigated.	£100 (0.2% of the total overall payments recommended to NHS organisations in this quarter by the PHSO)

Service Improvements	106 complaints involved recommendations such as changing procedures or training staff	An explanation of what Actions have been taken to address the failings in the report (3 complaints)
Other Actions	23 complaints involved other actions Such as asking an organisation to correct errors in medical records	None

7. Learning from Feedback

Implementing Learning to Improve Services

7.1 All Hospital/ MCSs/MLCO regularly receive their complaint data and review the outcomes of complaint investigations at the Hospital/ MCS Meetings. **Table 9** demonstrates how learning from a selection of complaints has been applied in practice to contribute to continuous service improvement within the Hospitals/ MCSs.

Table 9: Examples of learning from complaints to improve services, Quarter 3, 2018/19

Hospital/ MCS	Learning & Improvements
CSS	**Critical Care Units Wythenshawe – Perception of Staff Behaviour and Values** A family raised concerns regarding medical care provided to a patient prior to his death. The complaint was regarding the behaviour of staff whilst the patient was in Critical Care, which the family described as unprofessional. As a result of the complaint the patient's and family's experience was fed back anonymously to staff from Cardiothoracic Intensive Care Unit (ICU) and Adult ICU at unit meetings to raise their awareness of how their actions impacted on patient and relatives experiences. The feedback included the use of mobile phones and the internet, professionalism and how behaviour is perceived by patients and relatives. **Imaging Wythenshawe – Communication and Patient Experience** A patient who was undergoing a scan did not want to know the gender of her baby but was inadvertently told during the consultation when the sonographer told the sibling who was present they were having a sister. The patient felt that the Sonographer did not take any of their wishes into consideration and did not show remorse for the error. As a result of this complaint the member of staff was asked to reflect on their practice and the impact on patient experience and has since attended several courses on customer skills, notably, Sage & Thyme training, which teaches clinical and non-clinical staff at all levels, evidence-based communication skills to provide person-centred support. The member of staff also attended an NHS communication skills course, and a customer service skills training course.

UDHM	**Implant Funding** A patient initially complained in May 2018. The main concern raised related to the patient not being able to access NHS funded dental implant treatment at UDHM. The patient had been informed by their consultant that they did not meet the criteria for such treatment under the guidance based upon current Clinical Commissioning Group (CCG) guidance. **Findings** The patient had previously had implants fitted overseas, which had failed due to extensive periodontal disease. In view of this, the patient lacked enough bone to support the implants and was at higher risk of failed implants in the future. The patient was given alternative treatment options but still wanted to pursue funding for dental implants. The patient was dissatisfied with the formal response and a telephone meeting was held. A further CEO letter was sent following this meeting summarising the discussions at the meeting. A further letter was then received in December 2018 from the patient's MP in relation to the matter and a response detailing the assessment and outcome of the patient's condition and the reasons why the patient did not meet the criteria for funded dental implant treatment. The letter also explained the details of how this had been explained to the patients including a tele-conference meeting in an attempt to resolve the patients concerns. **Action** To review the provision of information provided to patients regarding NHS dental implant treatment in order to improve future communication.
MREH	**Clinic Waiting Time** A patient endured a 1 hour 15 minute wait in an Outpatient Department (OPD) clinic. **Findings** The patient attended clinic for a 9:10am appointment, and was called through for a member of staff to undertake their visual acuity at 9:35am. The patient expected to see the consultant who was unfortunately on leave that day. The Staff Nurse on duty was not aware the consultant was on leave and proceeded to find the consultant. Eventually another doctor saw the patient. contributed to the patient's long wait. The patient requested a refund of parking for the extra hour's parking due to the long wait in clinic. The Staff Nurse was unsure how to obtain the necessary form, and went to the Security Office to obtain the correct form. This also contributed to the patient's long wait. **Actions** A process has been put in place to ensure that staff are aware of the process for checking availability of specific doctors within a clinic when a patient requests to see a specific doctor.

	The Matron for the Outpatient Department has spoken with the nursing team within the outpatient department to ensure that all staff are aware of how to access the car parking reduction/exemption request form from the Hospital computer system to make the process more efficient in the future. This information will also be included in the local induction document for nursing staff who commence posts within the Outpatient Department on an ongoing basis.
WTWA (Heart and Lung)	**Cardiology – ACCU (Acute Coronary Care Unit)** A patient arrived on ACCU with a nurse from ED. The ED nurse was handing over the patient to the ACCU nurse whilst other staff members were transferring the patient onto the bed, during which time the patient became acutely unwell. As all of the staff were not aware of the patient's resuscitation status the resuscitation trolley and resuscitation team were requested. The patient's resuscitation status was then shared with clinical staff prior to any medical intervention; the relatives witnessed this and were clearly distressed. **Findings** ▪ Ineffective communication between clinical teams during patient transfer from ED to ACCU caused distress to the patient's relatives at a critical time when the patient was approaching end of life. ▪ Communication to the family following the patient's death regarding collection of the patient's death certificate. **Actions** ▪ The complaint response has been shared at the Cardiology Governance meeting for further discussion and learning, specifically relating to the identified breakdown in communication which resulted in unnecessary distress for the patient's family. ▪ The Trust sincerely apologised for the miscommunication between clinical teams. The response also identifies the mechanisms to be used to share learning following the incident, including discussion at ward meetings and staff safety huddles, and reflection with the medical staff regarding resuscitation status.
WTWA (Division of Medicine)	**Discharge Planning Communication** A gentleman's daughter made a complaint that her father had been discharged home from a medical ward without a package of care having been put in place. She felt the discharge was premature and also expressed concern that she was not informed of her father's discharge or given the opportunity to collect him from hospital. **Findings** The patient was assessed as having mental capacity to make decisions about his own care and treatment Nursing staff completed a social work referral with the patients consent to identify additional support that might be available for the patient following discharge. The patient met with social services on the ward and despite encouragement to accept support, declined and wanted to go home to continue to live independently. The patient was discharged the following day, no contact with the patient's family was attempted and hospital transport was arranged.

	Actions ▪ The ward staff reviewed the anonymised complaint together during a ward meeting to share learning. ▪ Acknowledgement that the patient should have been asked if they wished staff to contact family regarding transport home. The team agreed this will be actioned as part of the discharge checklist in future. ▪ Documentation regarding decision making and communication with family to be improved by ensuring correct utilisation of the discharge planning sheet in the nursing documentation.
WTWA (Division of Surgery)	**Communication** A parent attended an ENT appointment with their 5 year old child who was suffering ear pain and hearing loss. This appointment consisted of a consultation and a minor procedure. The parent raised concerns about the Consultant's conduct and communication skills during this consultation stating that the Consultant did not make eye contact, asked questions in an abrupt and dismissive manner and used inflammatory language regarding the child's hearing loss. The parent stated that the consultant did not address or communicate with her child directly, nor did they explain to the parent or child how the procedure would be carried out. During the procedure the parent was distressed that their child felt anxious and as a result of this, the procedure failed. **Findings** The parent asked the Consultant for additional clarification during the consultation and expressed their dissatisfaction with the Consultant's manner, communication skills and his failure to properly explain the diagnosis. Unfortunately this did not prompt the Consultant to review and change his conduct during the appointment or offer an apology at the time. The Consultant did not make any attempt to explain the procedure to the child, which resulted in unnecessary distress. No reassurance was offered to comfort the child when they became upset during the procedure. **Actions** The following actions were taken following receipt of the complaint: ▪ The ENT Consultant Clinical Service Lead addressed the complaint with the Consultant involved and affirmed that his behaviour was not acceptable and did not demonstrate compassion or care for the child or parent. ▪ A full face-to-face apology was offered to the family by the Consultant at the follow up appointment which was accepted by the family. ▪ At the child's follow up appointment, with the same Consultant the parent reported that the Consultant was fully engaged with the child and their conduct was much more positive. ▪ The complaint was used as an opportunity for staff to reflect on their conduct and behaviour and offers assurance that the Trust adopts an open, honest approach to complaints raised in line with the Trust Values and Behaviours framework. ▪ The outcome of the complaint has been shared amongst teams to promote learning and encourage staff to reflect upon their own behaviours.

MRI Medicine	A patient had multiple attendances to the Emergency Department (ED) between October 2017 and March 2018 and on each occasion was admitted to the hospital for ongoing care. The patient's social circumstances were difficult and the patient required assistance with personal hygiene. During each admission the patient experienced multiple ward moves and this complicated the arrangements for his discharge. This meant that the patient did not receive the continuity of care he would have received had his discharge been arranged by the same team. Additionally, with each ward move the ward teams' knowledge of the patient and his condition on admission lessoned and therefore there was a loss of a consistent understanding of the degree of the patient's self-neglect at home. The investigation identified a number of lessons that could be learnt regarding the care the patient received. **Key findings** ▪ A loss of momentum in managing the patient's integrated community care. Even when progress was made to engage the patient with the community teams, his recurrent admissions in quick succession meant that the plans to provide integrated community care outside of the hospital setting were not successful. This was linked, and reflective of, the fact that there was difficulty in developing joint working across health and social care and even when plans were agreed delays in converting the plans into actions were evident. ▪ The lack of communication with the patient's family provided another missed opportunity to ensure that care was consistent and appropriate plans were agreed to support the patient. This was again exacerbated by the number of in-hospital ward transfers and the loss of ward continuity by placement and discharge from varying wards. **Actions** Changes to address these issues are already underway and form much of the work that the hospital is undertaking in partnership with the MLCO to deliver better integration between community health and care services in Manchester. In recent months, the teams have already started to see the benefits of this closer working and are supporting discharges from hospital back into the community. Weekly meetings with the MLCO are part of this work, these are utilised to agree plans relating to complex patients and review patients with multiple admissions.
MRI SMS	**Delay in a patient's blood being taken in Haematology Day Unit** A patient reported they experienced a significant delay in having their blood taken and then a long delay in being seen by the consultant. **Lessons Learned** The investigation into the concerns raised by the patient identified: ▪ Patients attending the Haematology Day Unit should have their blood processed as 'urgent' rather than 'routine'. ▪ Blood samples processed as 'routine' took significantly longer resulting in an unacceptable length of time a patient had to stay on the Haematology Day Unit.

	Actions ▪ Development of a new process with the nursing team to ensure patients who need their blood samples to be sent as 'urgent' are identified clearly to the phlebotomy team at the start of the day. ▪ A process has been put in place which involves the nurse in charge contacting the laboratory and confirming that samples have been received and will be processed as urgent.
MRI Surgery	**Poor Experience during Inpatient Pathway** A complaint was received from a patient regarding her poor experience during her inpatient pathway from admission to discharge throughout a number of surgical departments. Some of the issues raised by this patient concerned cleanliness, privacy and dignity, culture and patient safety, as follows: ▪ Felt tick box pre-operative questionnaire was not appropriate and staff were not offering compassionate care. ▪ Medication left unattended. ▪ Poor condition of toilets on the ward. ▪ There was a 2/3 minute delay before staff in recovery noticed the patient's distress. ▪ Unhappy with patient transfer. ▪ Poor communication on the ward. ▪ Privacy & dignity whilst on the ward. **Actions** As a direct result of this complaint the following actions have been taken: ▪ Work has been undertaken to ensure the safe storage of medication and the timely completion of patient prescriptions is discussed at surgical induction. ▪ Further training was provided to staff in relation to pre-operative assessments and that each section of the pre-operative questionnaire is reviewed to explore with patients any areas of concern, or sections where the patient has been unable to complete the question. ▪ The introduction of a Senior Band 7 Nurse within the Department who will be responsible in undertaking additional training and overseeing all aspects of care provided ensuring privacy and dignity is achieved at all times. ▪ Following the local resolution meeting with the complainant the Head of Nursing for Surgery has spent significant time inspecting the condition and cleanliness of all areas across the Division of Surgery and there has been a substantial focus on raising the standards across all areas. This has included the involvement of Sodexo for inspections of their cleaning services but also overall environment audits. ▪ The Divisional Theatre Manager has ensured this patient's complaint regarding the delay she experienced in recovery before staff noticed her distress has been shared with the staff involved. It has also been shared with the wider Recovery team. The Theatre Manager expects to see an improved level of care and observation in the future for patients and the Educational Team for Theatres will monitor this to improve satisfaction of care whilst in the Theatre environment. ▪ The Bed Management Team across the Division now ensure that all patients and relatives are informed of any planned changes to their ward destination following any procedure from either theatre or ward moves within the surgical bed base.

	▪ The Lead Nurse for Ward 9 & 10 and the team on Ward 10 are working on an Improving Quality Programme (IQP) related to communication and how they can positively impact effective communication between staff and patients. ▪ The Site Director of Estates & Facilities ensured that the Sodexo Management Team made it clear to all Sodexo staff not to enter an area with a closed curtain unless they had checked with a member of nursing staff.
St Mary's Hospital	Saint Mary's Hospital has developed a range of Specialist Midwifery services to support women throughout their pregnancy from the normal and low risk births through to the complex high risk pregnancies. The role of the midwife is to support the women throughout her pregnancy, safeguard her health and that of her unborn infant and raise concerns where women appear to be in a vulnerable relationship regardless of racial background. The Obstetric team focus on the delivery of personalised care where the wider social issues and individual expectations are taken into account through the drawing up of a Pregnancy plan. **Actions** The cultural and religious preference/needs of women must be identified and accommodated where possible: So all staff members have been reminded that: ▪ As part of this women's birth plan a preference that no male personnel will enter the room at any point unless it was an emergency or no female member of staff were available is clearly communicated to all staff. ▪ The importance of maintaining the privacy and dignity of the women and only entering the room with the women's consent. ▪ This is a teaching hospital and whilst training is fully supported, the women's consent must be obtained before medical, and midwifery students are allowed to approach. As part of the Equality, Diversity and Human Rights training within Saint Mary's Hospital, an awareness session of unconscious bias / prejudice and cultural needs will be shared across the Managed Clinical Services.
RMCH	**Communication and Nursing Care** A complaint was received from a patient's mother raising concerns about the miscommunication around parental visiting, support around breast feeding and poor communication with parents and between teams around the plan of care. Mum advised that when her daughter was being admitted to the ward, staff had explained that only one parent could stay overnight. On investigation of this concern it was identified that that the ward information leaflet was unclear, in that it supported open visiting for both parents' day and night. Also highlighted in the complaint, was that the usual support offered to a mum who was breast feeding was not offered as it should have been due to a new member of staff not being aware of the additional support the hospital would usually provide.

	On investigating the matter, it was also clear that ward processes at the weekend around when to expect a medical review had not been communicated to mum. It was also felt that the explanation around the child's plan of care had also not been made clear by the medical team. **Actions** As a result of the complaint and to avoid a similar incident happening in the future the following actions have been agreed: ▪ The Matron will review and amend the wording on the Inpatient information leaflet available on the internet. The Ward Manager will liaise with midwifery colleagues to incorporate breast feeding checks during their training sessions in order to raise staff awareness. ▪ The Ward Manager will remind all nursing staff to explain to children and their families the routine of the ward at weekends and how the medical ward round works. ▪ The Consultant will liaise with all medical personnel involved in the child's care and identify how concerns can be raised if there are issues identified related to communication between our team and families.
Corporate Estates and Facilities	**Signage** A number of complaints have highlighted the difficulties that patients are experiencing with wayfinding from Oxford Road when arriving by bus, particularly since the 147 has stopped travelling through the site. **Actions** In response the Facilities Management Team are reviewing signage at the site perimeter to improve wayfinding for patients and visitors.

8. Equality and Diversity Monitoring Information

8.1 **Table 10** provides Equality and Diversity information gathered from complainants for Quarter 3, 2018/19. It is evident that the collection of this information is not representative of complainants due to the low response rates. The Corporate PALS team continue to explore opportunities to improve the quantity and subsequently quality of this data.

8.2 Analysis of the limited data in Quarter 3, 2018/19 has highlighted complainants that identify having a disability are low in number and not representative of the overall patient population. This has been identified as an area of focus and specifically that no complaints have been received from patients who report they have a learning difficulty/ disability. The accessibility of the complaint system for patients with a disability is an ongoing improvement work stream in collaboration with the Equality, Diversity and Inclusion team.

8.3 During Quarter 3, 2018/19 meetings have been held with the Equality, Diversity and Inclusion team. During Quarter 4, 2018/19 the Corporate Team will be supported by the Equality, Diversity and Inclusion team to establish a more robust process to improve the capture of equality and diversity data from patients and relatives who raise concerns and complainants.

8.4 A specific action during Quarter 3 has involved the review and update of the Easy Read Patient Experience Leaflet which has been reviewed and approved by the Learning and Disability Patient, Parent and Carer Forum.

Figure 1: Easy Read Patient Leaflet

Table 10: nd Div

Disability	**No.**
Yes	29
No	59
Not Disclosed	248
Total	**336**
Disability Type	
Learning Difficulty/Disability	0
Long-Standing Illness Or Health Condition	13
Mental Health Condition	1
No Disability	0
Other Disability	1
Physical Impairment	11
Sensory Impairment	3
Not Disclosed	307
Total	**336**
Gender	
Male	127
Female	202
Transgender	0
Not disclosed	7
Total	**336**
Sexual Orientation	
Heterosexual	76
Lesbian / Gay/Bi-sexual	6
Do not wish to answer	4
Not disclosed	250
Total	**336**

Religion/Belief	
Buddhist	1
Christianity (All Denominations)	48
Do Not Wish To Answer	245
Muslim	7
No Religion	31
Other	1
Sikh	0
Jewish	3
Hindu	0
Not disclosed	0
Total	**336**
Ethnic Group	
White – British	87
White – Irish	2
White – Other	3
Asian or Asian British – Bangladeshi	1
Asian or Asian British – Indian	3
Asian or Asian British – Pakistani	1
Asian or Asian British – Other Asian	4
Black or Black British – Caribbean	2
Black or Black British – African	2
Black or Black British – other Black	1
Mixed – White and Asian	2
Mixed - White and Black Caribbean	2
Mixed – Other Mixed	2
Any other ethnic group	2
Do not wish to answer	62
Not stated	160
Total	**336**

9. Quality Improvements

9.1 Improvements, Quarter 3, 2018/19

9.1.1 Benefits of the new MFT Ulysses Complaint Module

Following the introduction of the new single Ulysses Complaint Module in Quarter 1, 2018/19, work has continued throughout Quarter 2 and 3, 2018/19 tailoring and configuring the MFT Module to meet the specific needs of the Hospitals/MCSs and the MLCO. The system provides a single streamlined clinical governance process across all sites using the same data sets. The database is accessible for all staff across all sites within MFT and enables a robust data sharing system across the Trust. Key aspects of this reporting alignment has been successfully achieved and work will continue until full alignment is realised by Quarter 4, 2018/19.

9.1.2 'Tell us Today'

'Tell us Today' enables inpatients and families to escalate concerns in real time via a dedicated telephone number to a senior nurse or manager in order that issues can be resolved, the patient's experience improved and potentially a complaint averted.

Following the re-launch of 'Tell us Today' in Quarter 2, 2018/19 only 3 calls were recorded during Quarter 3, 2018/19. During Quarter 4, 2018/19 the corporate team will undertake a review of the process and source feedback from senior nurses and managers to identify areas for improvement.

9.1.3 Educational Sessions

The Corporate PALS team facilitated an educational session at University of Manchester, School of Health Sciences, Faculty of Biology, Medicine and Health. The session was attended by clinical scientists undertaking their Higher Specialist Scientific Training. The session was very well received with the students reporting that it was the most useful part of their on-site training for that particular module.

Following the previous successful educational sessions for staff involved in responding to complaints, the Corporate PALS team facilitated an educational session in Quarter 3, 2018/19 with the current intake of General Management Officer Trainees.

In Quarter 3, 2018/19 educational sessions were facilitated by Modern Government for staff in the Royal Manchester Children's Hospital and the Manchester Royal Infirmary. The sessions were very well received and the feedback received from Trust staff included the following:

- A very informative thought provoking session which has influenced my practice when responding to question concerns and complaints.
- I found this course very helpful and feel I have more confidence in replying to complaints in to the future.
- The course was very interesting. Working in groups was fun. Very good presenter and made the day very pleasurable.
- Presenter is knowledgeable. The content was highly relevant to my role; providing structure to the generation of compassionate responses to complaints. This has been a most interesting development study day. Thank you.

9.1.4 Complainant's Satisfaction Survey

The Complaints Satisfaction Survey is based upon ***'My Expectations'***[1] paper and has been developed by the Picker Institute. It is sent to complainants covering all MFT Hospitals/MCS/MLCO and during Quarter 3, 2018/19 67 responses to the survey were received.

Survey results for Quarter 3, 2018/19 indicate:

- 89.80% of complainants felt they were made aware of their right to take their complaint further, if they were not completely satisfied with the outcome and/or recommendations.
- 76.19% of complainants felt that they received acknowledgement of their complaint within an acceptable time frame.
- 66.13% of complainants found it easy to make their complaint.
- 49.21% of complainants felt that they were taken seriously when they first raised their complaint.
- 45.90% of complainants received the outcome of their complaint within the given timescale.
- 38.71% of complainants felt that they received an explanation of how their complaint would be used to improve services.

It is reassuring that patients were made aware of how to seek further assistance with their complaint should they remain unhappy or dissatisfied. However, it is evident from the results that further improvements to our processes are required, with an initial specific focus on improving the quality of the complaint response and its timeliness.

The Head of Customer Services will increase the provision of focused training and awareness sessions during Quarter 4, 2018/19.

Comments received during Quarter 3, 2018/19 include the following:

- My complaints were understood by PALS staff, but when I got CEO answers, I continued to feel brushed aside and I am still not happy.
- It ensured that the future care was handled professionally and in a timely manner and has improved communication greatly.
- The response was clearly set out and dealt with each point (complaint) individually. Each point stated what had gone wrong and measures that would be taken to ensure the issues raised would not reoccur.
- It felt too long after the event that I had feedback and they would not identify the nurse on the ward my complaint focussed on.
- I felt that the wagons were rolled into a circle and felt to some extent the issue was whitewashed.
- Seems that people would give them information about what went wrong but not give me that information. In the end I doubt it made any difference.
- Very courteous. Explained everything very well. Very apologetic for mistakes made. We were impressed with their attitude.

9.1.5 Complaint Response Audit

During Quarter 3, 2018/19 a Complaint Quality Audit and Analysis Tools have been developed. The intention of the tool is to provide a measurable quality framework for complaint responses to meet in order to comply with the Trust's expected quality standards for formal complaint response letter writing.

The audit tool utilised focuses on the following aspects of the written response:

- **Plain English:** This section focuses on the use of appropriate grammar, punctuation, spelling, and sentence structure with the inclusion of explanations of medical terminology when required.

- **Tone:** This section focuses on the application of the Trust values, demonstrating care and compassion, transparency, understanding of the complainants concerns and appropriate personalisation.
- **Formatting:** This section focuses on professionalism, consistency, accuracy and absence of errors as well as inclusion of contact details for any further interaction
- **Content:** This section focuses on ensuring the response to the complaint is fulsome, with appropriate explanations, apologies (and or condolences) and details of improvements as a result of the feedback received.

The Assistant Chief Nurse (Quality and Professional Practice) and the Deputy Director of Nursing (WTWA) have piloted the Quality Audit and Analysis Tools on a sample of WTWA complaint responses to test the usability and usefulness of the tools.

An initial analysis of the pilot has identified that the Audit and Analysis tools were easy to use and from the sample of 23 responses the content of the response performed highest, whilst the tone of the response offered the greatest opportunity for improvement. Detailed analysis of the findings is scheduled in Quarter 4, 2018/19.

9.1.6 Standard Operation Procedures

Work continued during Quarter 3, 2018/19 reviewing the Formal Complaints and PALS Standard Operating Procedures to ensure Manchester University NHS Foundation Trust maintains compliance with the NHS Complaints Regulations (2009).

9.2 Future Planned Improvements

9.2.1 Relocation of PALS office at Wythenshawe Hospital

Plans for the new PALS office have now been approved and work is scheduled to commence at the end of January 2019. This is an exciting and progressive time for PALS, and most importantly ensures patients; families and their carers are able to access a well-located PALS office.

9.2.2 Education and Training

Following the previous successful educational session facilitated by the Parliamentary and Health Service Ombudsman (PHSO) further sessions are currently being arranged for Quarter 4, 2018/19 and Quarter 1, 2019/20.

Further ***Safeguard Master Classes*** facilitated by the Head of Customer Services and PALS Manager are planned for Quarter 4, 2018/19. The Master Classes will focus on improving staff knowledge and skills in relation to using Ulysses for Hospital/ MCS and the MLCO management and reporting of complaints.

Planning is underway with the Trust's OD&T Department regarding the development of an in-house ***Complaints letter writing training package.*** The aim of the training course will be to provide delegates with the tools of how to improve content, structure and style of letters they produce by adopting best practice standards**.**

9.2.3 Complaint Response Audit

The Complaint Quality Audit and Analysis Tools will be made available for use by all Hospital/ MCS and the MCLO teams to review the quality of responses.

9.2.4 Complaints Satisfaction Survey

In order to ensure the feedback is disseminated Trust wide and ensure continuous improvement the development of a Complaints Satisfaction Survey Dashboard is planned in Quarter 4, 2018/19.

10. Conclusion

The Group Board of Directors is asked to note the content of the Quarter 3, 2018/19 Complaints Report and the on-going work of the corporate teams and the Hospital/ MCS and MLCO teams to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to continuously improve the patient's experience. In conclusion, we will:

- Continue to monitor complaint response timescales against expected response timescales.
- Continue to offer Corporate Nursing Support to Hospitals/ MCSs/ MLCO where performance is deteriorating.
- Continue to review and embed recommendations within MFT's policies from National Guidance, including the recently published 'Ombudsman's Clinical Standard' and ***'Complaints about the NHS in England (Quarter 1 – 2018/2019)'***.
- Continue to progress the improvements as outlined in this report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Executive Director of Human & Corporate Resources
Paper prepared by:	Margot Johnson, Executive Director of Workforce & OD Helen Farrington, Deputy Director of Workforce & OD
Date of paper:	March 2019
Subject:	MFT Staff Survey Results 2018 and Action Plan
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	The national NHS Staff Survey results are the primary method by which we measure how well we support the well-being of our workforce and enable each member of our staff to reach their full potential. This is essential to maintaining improved organisational performance.
Recommendations:	The Group Board of Directors is asked to note the strengths and areas for improvement in the staff survey and approve the actions outlined on
Contact:	Name: Margot Johnson, Executive Director of Workforce & OD Tel: 0161 276 4795

1.0 Background and Context

1.1 This paper provides an overview of the 2018 national Staff Survey results. The purpose is to provide the Board of Directors with detail on the Group level results and a summary of the results for Hospitals, Managed Clinical Services (MCS), Manchester Local Care Organisation (MLCO), Research and Innovation (R & I) and Corporate teams. It also includes a review of progress towards delivering the action plan agreed following the 2017 survey.

1.2 The staff survey is the Trust's primary method by which organisational culture is measured. This includes how well led and how led are staff and whether they feel sufficiently supported to enable them to fulfil their potential. This can be best described as staff experience.

1.3 The culture MFT seeks to create is described in the MFT Leadership and Culture Strategy. The overall aim of the MFT Leadership and Culture strategy is to develop a compassionate, inclusive and high quality care culture that is underpinned by exemplary leadership and ensures the best outcomes for people; improving the health of our local population.

1.4 Successfully delivering this strategy will mean MFT will have developed:

- a thriving, resilient, healthy and high performing Trust
- a learning organisation built for agility and adaptability
- an inspiring and shared vision focussed on quality that creates a sense of purpose, pride and belonging
- fully integrated cohesive teams who work effectively together, across other teams and organisations
- greater connectivity to and understanding of our communities to ensure better health outcomes
- staff who are willing and able to be leaders of change
- ownership and accountability for high quality care at all levels
- leadership practice and behaviours in line with the values and culture that are defined, shared and observed
- high levels of staff engagement
- as an employer of choice in Manchester and beyond
- Evidence-based practice in retaining, developing and acquiring staff required to deliver the vision.

1.5 The 2018 NHS Staff Survey results are based on staff in post and organisational structures as at 1st September 2018. Therefore, the 2018 survey is the first to be reported nationally as Manchester University NHS Foundation Trust (MFT). **7037 MFT staff responded to the survey.**

1.6 MFT received two reports: a national one issued by the Survey Co-ordination Centre (SCC) that is published and available for public scrutiny and provides some benchmark data; and a private report issued by Quality Health. The latter provides a more detailed report on our own results but doesn't provide national benchmark data. Both reports are referred to in this paper.

2.0. Changes to national reporting of the Staff Survey results

2.1 There have been a number of significant changes to the reporting format used by the SCC for the 2018 results. The most significant of these is that the previously-used 32 Key Findings have been replaced by 10 Key Themes. These 10 themes cover around 60% of the questions included in the survey. The remaining questions are reported separately.

2.2 The following changes have also been made:

- The adoption of a universal 10 point scale for the reporting of Key Themes, replacing a combination of a 5 point scale and percentage score reporting. Where appropriate and available, the SCC have recalculated 2017 data to allow for comparisons to be made at Group level only.
- data in reports produced by the SCC is now to one decimal point, rather than the previous two decimal points
- percentiles are no longer included in national reports to identify 'above/below' average scores; average, best and worst scores continue to be included.

2.3 As a result of these changes, the style, presentation and detail in the reports produced by the SCC is significantly different to previous years. MFT is regarded as a new organisation for 2018 and so trend data from the SCC is currently limited to 2017 and at Group level only.

2.4 National reporting for 2018 includes results by Group/Hospital/MCS/MCLO and Corporate/R & I, at 'Key Theme-level', with question-level reporting also provided at Group Level. The national report also includes benchmarked data for individual questions at Group level. In national reporting, our benchmark group is 'combined acute and community trusts'. We also benchmark against the Shelford Group and against Acute Greater Manchester NHS trusts.

2.5 Additional question-level data is available through the results portal of our 2018 survey partner, Quality Health. This provides for a more granular analysis across a range of variables (e.g. protected characteristics, departments).

3.0. Group Results Summary - Staff Engagement

3.1 At the time of writing this report NHS Employers had not issued their summary report on the national picture. However based on the data published on the national staff survey site scores for overall staff engagement have remained static, although there has been an improvement in those scores related to recommendation of organisations as a place to receive treatment and to work. There has also been improvements in scores concerning staff recognition, such as recognition for good work and staff feeing that their organisation values their work. These are reflected in the scores for MFT, with the increases in scores being greater than at national level. Health and wellbeing is an area that has declined nationally, with the overall theme score being 0.1 down on the previous year. At MFT, this theme score has improved by 0.1, reversing the decline seen in 2017.

3.2 As in previous years, the overall staff engagement score is based on three factors: recommendation of the organisation as a place to work/receive treatment (advocacy) staff motivation at work (motivation); and contribution towards improvements at work (involvement).

3.3 The overall staff engagement score has increased from 7.0 to 7.1 (rounded), with the actual increase being 0.13. All three staff engagement factors have seen an improvement in scores.

3.4 MFT has improved in 8 out of the 9 Key Themes where data is available for 2017.

3.5 MFT is average across all 10 themes and scoring 0.1 – 0.2 higher than the sector average for 6 of the 10 Key Themes and 0.1 lower in two: Equality, Diversity and Inclusion and Quality of Appraisals.

3.6 There have been improvements in the scores for 67 of the 79 questions where data for 2017 is available. Of these, 50 are reported in our Quality Health report as being a statistically significant improvement. The greatest improvement has been in questions relating to the Key Theme 'Safety Culture'.

3.7 There has been 1 statistically significant decrease in scores at question-level. The question is 'I know who the senior managers are here'.

3.8 The chart below compares the 2017 and 2018 staff engagement scores across the factors of advocacy, motivation and involvement:

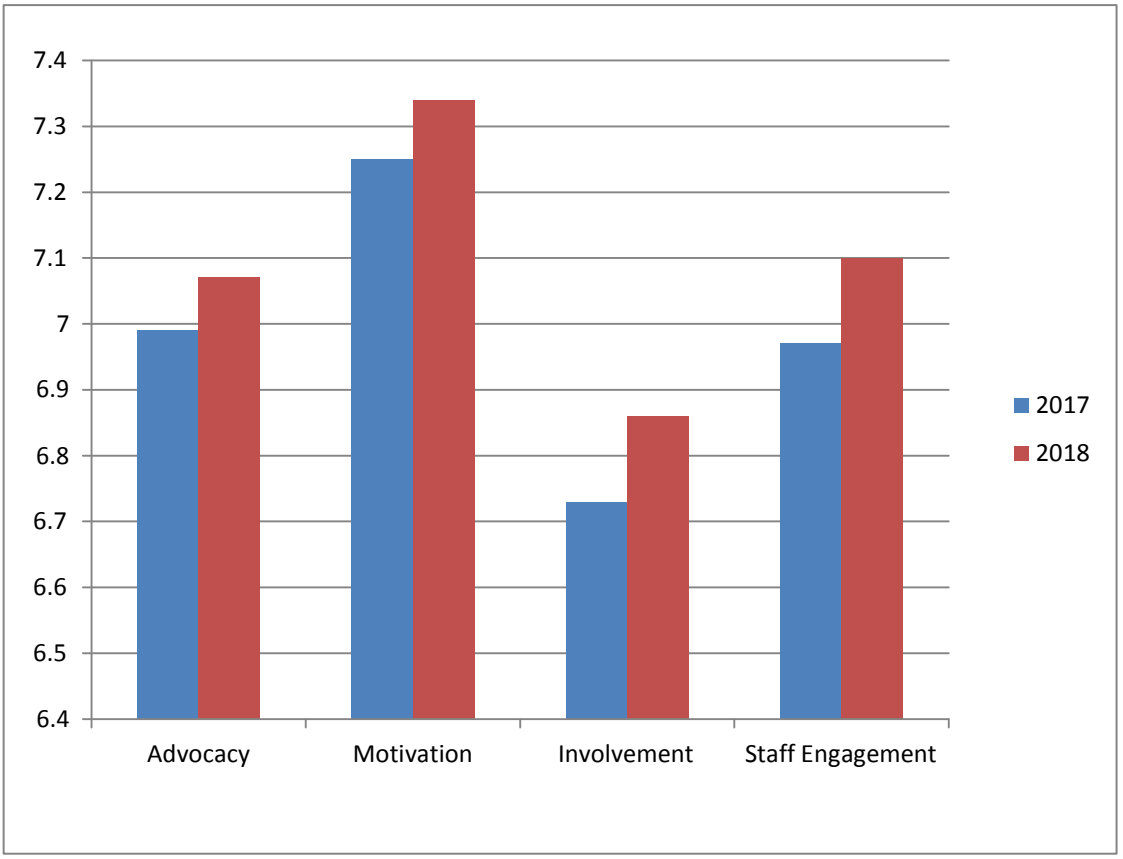


Chart 1: Staff engagement MFT Group 2017-2018

3.9 National Benchmarking – Shelford group

The table below shows how the Trust compares to our peers in the Shelford Group for our staff engagement score. We are now ranked 5th for overall staff engagement, compared with 8th in 2017.

Trust	2017	2018	Change
Guys and St. Thomas's	7.5	7.4	-0.1
Newcastle Upon Tyne Hospitals	7.3	7.3	-
Cambridge University Hospitals	7.1	7.2	+0.1
University College London Hospital	7.2	7.2	-
MFT	**7.0**	**7.1**	**+0.1**
Imperial College Healthcare	7.1	7.0	-0.1
Sheffield Teaching Hospitals	7.1	7.0	-0.1
University Hospitals Birmingham	*	7.0	*
Oxford University Hospitals	7.0	6.9	-0.1
Kings College Hospital	6.8	6.8	-

Table 1: Benchmarking – Shelford Group *New organisation - no public data

3.10 Regional Benchmarking- Greater Manchester Acute Trusts

The table below shows how the Trust compares to other NHS trusts in Greater Manchester for the overall staff engagement score. We are now ranked equal 2nd, compared with 5th in 2017.

Trust	2017	2017	Change
Bolton	7.1	7.3	+0.2
MFT	**7.0**	**7.1**	**+0.1**
Salford Royal	7.0	7.1	+0.1
Tameside and Glossop Hospitals	7.2	7.1	-0.1
Wrightington, Wigan and Leigh	7.4	7.0	-0.4
Stockport	6.8	6.9	+0.1
Pennine Acute Hospitals	6.8	6.8	-

Table 2: Benchmarking – Acute Greater Manchester Trusts

4.0. Group Results Summary – Key Themes and Individual Questions, including optional questions

4.1 Key Themes

4.1.1 Previously, the Staff Survey results were published around 32 Key Findings. These have been replaced by 10 Key Themes. Survey questions not covered by the 10 themes are reported individually.

4.1.2 The table below shows the Key Themes results for 2018, compared with our sector average and with the equivalent scores for 2017. A comparison with the best and worst performing trusts in our sector is provided in Appendix 1.

Theme	2018 MFT	2017 MFT	2018 Sector
Equality, Diversity and Inclusion	9.1	9.0	9.2
Health and Wellbeing	6.0	5.9	5.9
Immediate Managers	6.8	6.7	6.8
Morale	6.2	New	6.2
Quality of Appraisals	5.3	5.2	5.4
Quality of Care	7.5	7.4	7.4
Safe Environment – Bullying & Harassment	8.3	8.2	8.1
Safe Environment - Violence	9.6	9.6	9.5
Safety Culture	6.8	6.7	6.7
Staff Engagement	7.1	7.0	7.0

Table 3: Group Key Themes' scores

Favourable difference since 2017 and against benchmark average
Within 01% of absolute average of benchmark group

4.1.3 Therefore, MFT scores have improved since 2017 for 8 of the 9 Key Themes where data is available, with one theme unchanged.

4.1.4 MFT is average across all 10 themes and scoring 0.1 – 0.2 higher than the sector average for 6 of the 10 Key Themes and 0.1 lower in two: Equality, Diversity and Inclusion and Quality of Appraisals.

4.1.5 All 9 Key Themes where data for 2017 is available saw a statistically significant improvement in two or more contributory questions, with all six questions relating to Safety Culture showing a statistically significant improvement.

4.2 Individual Questions - mandatory

4.2.1 Below is a summary of performance against the question-level scores, with an overall comparison with the scores in 2017 and the benchmark sector average for 2018. Where applicable, it is noted if changes in scores since 2017 are statistically significant differences as reported by Quality Health. The table excludes those questions where there is no difference in score and/or the question is new for 2018.

No of questions where score has increased on 2017		**67**
No that are statistically significant increases		**50**
No of questions where score has decreased on 2017		**7**
No that are statistically significant decreases		**1**
No of questions where score is above the benchmark sector average		**60**
No of questions where score is below the benchmark sector average		**26**

Table 4: Summary comparison of question-level scores - 2017-18

4.3 Where we are improving / doing well

4.3.1 The following questions recorded an improvement of 4% or more in scores, all of which were reported as statistically significant and above the average score for the benchmark group

- I am satisfied with the recognition I get for good work +8%
- Satisfaction with my level of pay +7%
- My organisation treats staff who are involved in an error, near miss or incident fairly +6%
- I am able to meet the conflicting demands on my time at work +4%
- Satisfaction with the extent to which my organisation values my work +4%
- I am able to deliver the care I aspire to +4%
- Not feeling pressure from my manager to come to work when feeling unwell in the past 3 months +4%
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again +4%
- We are given feedback about changes made in response to reported errors, near misses and incidents +4
- I am confident that my organisation would address my concerns about unsafe clinical practice +4%
- Training, learning and development needs are identified during appraisal +4%

4.3.2 The following questions recorded a score of 3% or more **above** the benchmark sector average:

- When errors, near missies or incidents are reported, my organisation takes action to ensure that they do not happen again
- We are given feedback about changes made in response to reported errors, near misses and incidents
- If a friend or relative needed treatment I would be happy with the standard or care provided by this organisation
- Feedback from patients/service users is used to make informed decisions within my directorate/department
- I am able to make improvements happen in my area of work
- Staff (not) experiencing musculoskeletal problems as a results of work activities in the past 12 months
- Staff (not) experiencing harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public

- I would recommend my organisation as a place to work

4.4 Where we need to improve

4.4.1 The following question recorded a statistically significant decrease:

- I know who the senior managers are here -1%

4.4.2 The following questions recorded a score of 1% or more **below** the benchmark sector average:

- (If you have a disability) Has your employer made adequate adjustments to enable you to carry out your work?
- Unpaid hours worked over and above contracted hours
- Agreeing that the organisation takes positive action on health and well being
- Reporting last experience of harassment, bullying or abuse at work
- Agreeing that the organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age
- My last appraisal helped me agree clear objectives for my work
- My manager supported me to receive training, learning or development needs identified through appraisal
- I will probably look for a job in a new organisation in the next 12 months
- I am satisfied with the opportunities I have to use my skills.

4.5. Individual questions - optional

4.5.1 For the 2018 survey, MFT included questions on the Trust Values and on Leadership and Career Development. These are standardised questions which allow for comparisons with previous years and the sector benchmark, but are excluded from our public report from the Survey Co-ordination Centre.

4.5.2 MFT scores for the three questions about Values were within 1% of the benchmark sector score provided by Quality Health, with 94% of staff having awareness of the new Trust Values

4.5.3 Of the 17 questions covering Leadership and Career Development, the following were reported by Quality Health as higher than *their* sector average, with the difference being statistically significant:

- I am encouraged to become a leader in my area of work (55%)
- I have the capability to become a leader in my area of work'(72%).

4.5.4 59% of staff reported that MFT had a clear vision for the future, with 42% reporting that they felt part of the organisation's vision for the future.

5.0 Summary of performance against 5 key priority areas and Group actions agreed following the 2017 Staff Survey

5.1 Following the analysis of the 2017 staff survey results, the following priority areas for 2018 were agreed at the Trust Board in May 2018:

- **Staff engagement** particularly supporting staff to implement improvements
- **Quality of Appraisals**
- **Effective Team-working**
- **Health and well-being**
- **Equal opportunities and discrimination**

5.1.1 Staff Engagement

Scores for all 9 questions that contribute to the Key Theme Staff Engagement score have increased on 2017; 8 of these increases have been identified as statistically significant (2 out of 3 for questions about implementing improvements). There has been an increase in Key Theme score from 6.97 to 7.10. against a sector average of 7.0 (rounded).

5.1.2 Quality of Appraisals

Scores for all 4 questions that contribute to the Key Theme Quality of Appraisals score have increased on 2017, 2 of which have been identified as statistically significant. There has been an increase in Key Theme score from 5.19 to 5.33 against a sector average of 5.4 (rounded).

5.1.3 Effective Team Working

Teamworking is not a Key Theme. However, the two questions previously linked to the former effective teamworking Key Finding have both seen a statistically significant increase in scores.

5.1.4 Health and Wellbeing

Scores for all 5 questions that contribute to the Key Theme Health and Wellbeing score have increased on 2017. Four of these increases have been identified as statistically significant. There has been an increase in Key Theme score from 5.89 to 5.97 against a sector average of 5.9 (rounded).

5.1.5 Equal opportunities and discrimination

Scores for all 4 questions that contribute to the Key Theme Equality, Diversity and Inclusion score have increased on 2017. Two of these increases have been identified as statistically significant. There has been an increase in Key Theme score from 8.99 to 9.09. against a sector average of 9.2 (rounded).

5.2. 2018-19 Group Actions

5.2.1 Below is a brief summary of Group level actions that were agreed for 2018-19 and the progress made:

a) Developing and embedding the MFT vision and Values and Behaviours

   – *The MFT Vision, Values and behavioural framework were launched in July 2018. They have been incorporated into the Trust induction and into the new Trust appraisal scheme launching in April 2019.*

b) Implementing and spread of the MFT 'Tackling Poor Behaviours Campaign'

   – *A review of Freedom to Speak up and subsequently a new programme has been implemented across the Trust. Hate Crime reporting is now in its pilot phase of delivery. A new multi-disciplinary approach for managing conflict and disruption is being brought together by the HR Directors to create a consistent approach across MFT. A task and finish group is in place chaired by the Director of clinical Governance making the key link of impact on patient safety for poor behaviour.*

c) Continue to and where needed further develop leadership and change capability development for all staff

   – *The Greater Manchester Mary Seacole programme, hosted by MFT, launched in May 2018 and 64 staff have successfully completed the programme and a further 100 have either started or registered.*
   – *A new clinical leadership programme for experienced consultants launched in September 2018, alongside our continuing leadership programme for newly appointed consultants.*
   – *Training for new first line managers has also been revised under the LEAD brand.*
   – *Cohort 3 of the MFT Graduate Management Programme is in place with 16 participants*
   – *Over 50 staff are completing the Chartered Management Degree Programme*
   – *Launched the Innovators of the Future programme in partnership with MMU*

d) Continue to build quality improvement capability through implementation of the Transformation Strategy

   – *We have revised and updated the Quality Improvement and Change training delivered through the AQUA partnership.*

e) Review and establish an appraisal process for MFT including an appraisal quality assessment

   – *A new appraisal process for MFT has been designed and will launch in April 2019. We have monitored the quality of appraisal through 2018-19 using the same methodology as in the staff survey.*

f) Continue to assess staff engagement and culture through diagnostics and the quarterly pulse checks

   – *The programme of quarterly pulse checks has continued throughout 2018-19.*

g) Develop and implement a high performing team framework

- *The Affina Team journey approach to developing high performing teams has launched. This trains staff as team coaches (64 to date) to work with team leaders to develop their teams, using a highly structured and evidence-based approach.61 teams are currently actively involved.*

h) Developing and promoting an range of opportunities and support for staff on wellbeing including the delivery of Schwartz rounds, and a 24hr employee assistance helpline

- *A 24hr employee assistance helpline and programme is now available to all MFT staff.*
- *Schwartz Rounds have continued throughout 2018-19 and launched at the Wythenshawe site in February 2019.*
- *The Trust has built into its wellbeing offer the Team MFT running programme including the Manchester 10K and supporting colleague to join team activities such as Park Run and monthly challenges*

i) Establish a MFT Equality & Diversity Strategy

- *This has been developed during to 2018-19 and is scheduled to launch in May 2019*
- *The strategy includes a response to the Workforce Race Equality Standard as well as the new Workforce Disability Equality Standard. With a programme developed that will be launch in March 2019 to support more BME managers into senior leadership posts and to improve the staff experience of staff with disabilities*

j) Roll out Diverse panels across MFT and deliver the Trust wide actions plans for the Workforce Race Equality Standard as well as the new Workforce Disability Equality Standard

k) Continued roll out and embedding of What Matters to Me for staff and patients

- *This has continued throughout 2018-19. It has included What Matters to Me masterclasses and First Impressions training. What Matters to Me has also been incorporated into the revised trust induction and new appraisal.*

l) Development of MFT Bee Brilliant Quality Event which provides nurses and midwives the opportunity to celebrate good practice and develop improvements in line with the WMTM Patient Experience Programme Themes which include, Positive Communication, Leadership and Culture, Our Staff Matter (health and wellbeing).

- *There is a rolling programme of individually-themed Bee Brilliant Quality Events across MFT.*

m) Development of Culture Survey, as part of the Trust's Accreditation programme, to provide ward/ departmental data for Ward Departmental Managers to identify areas for improvement at team level.

– *The Trust Accreditation programme includes a Culture Survey, allowing for data on staff experience to be available at individual ward level. This complements the staff and pulse survey work.*

6.0 Hospital/MCS/Corporate summary

6.1 Reports at Hospital/MCS- level, and for the MLCO, Corporate Departments and R & I, are provided by the SCC for Key Themes only. Historical data is not provided in the report and a direct comparison with the scores for 2017 is not currently available due to the changes in the scoring methodology nationally. Additional question-level data is available through the Quality Health results portal and this will allow for a manual comparison to be made with question-level results from 2017,

6.2 The chart below shows the overall staff engagement score for each Hospital/MCS and for the MLCO, corporate departments and R & I:

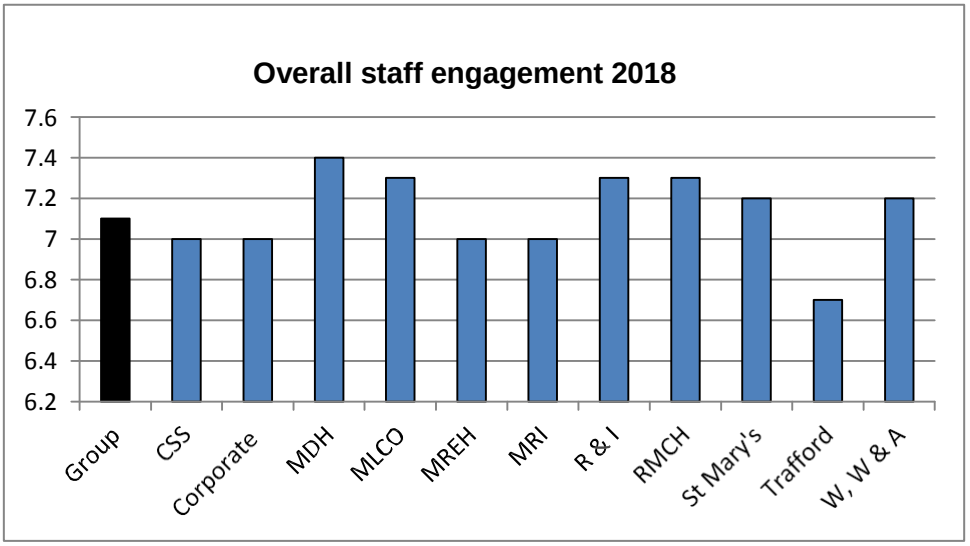


Chart 3: Overall staff engagement scores by Hospital/MCS/Corporate area

6.3 Appendix 2 shows the results for each Key Theme by Hospital/MCS and for the MLCO, Corporate and R & I.

6.4 Question-level data has been provided to each Hospital/MCS and for the MLCO, corporate departments and R & I, to allow for comparisons to be made against the Group, sector and internal benchmarks.

7.0 Survey free text comments

7.1 Staff are given the opportunity to add unattributed free text comments when they complete the survey. As yet, these comments are not available to MFT. When they are, a thematic analysis will be undertaken to identify key areas of concern, opportunities for improvement and to acknowledge concerns.

8.0 Actions for 2019/20:

8.1 The workforce Group-level actions planned for 2019-20 that will address the priority areas for improvement identified by staff in the survey, and further build on existing strengths are outlined in our Workforce Strategy and Implementation plan, Leadership and Culture Strategy and soon to launched ED&I strategy.

8.2 Hospital and MCS specific actions are outlined in the Annual Plans for each and are aligned to the Group plans.

8.3 For the 2019 the priority areas for improvement will focus on the key themes below with the aim to achieve above average against our benchmark group:

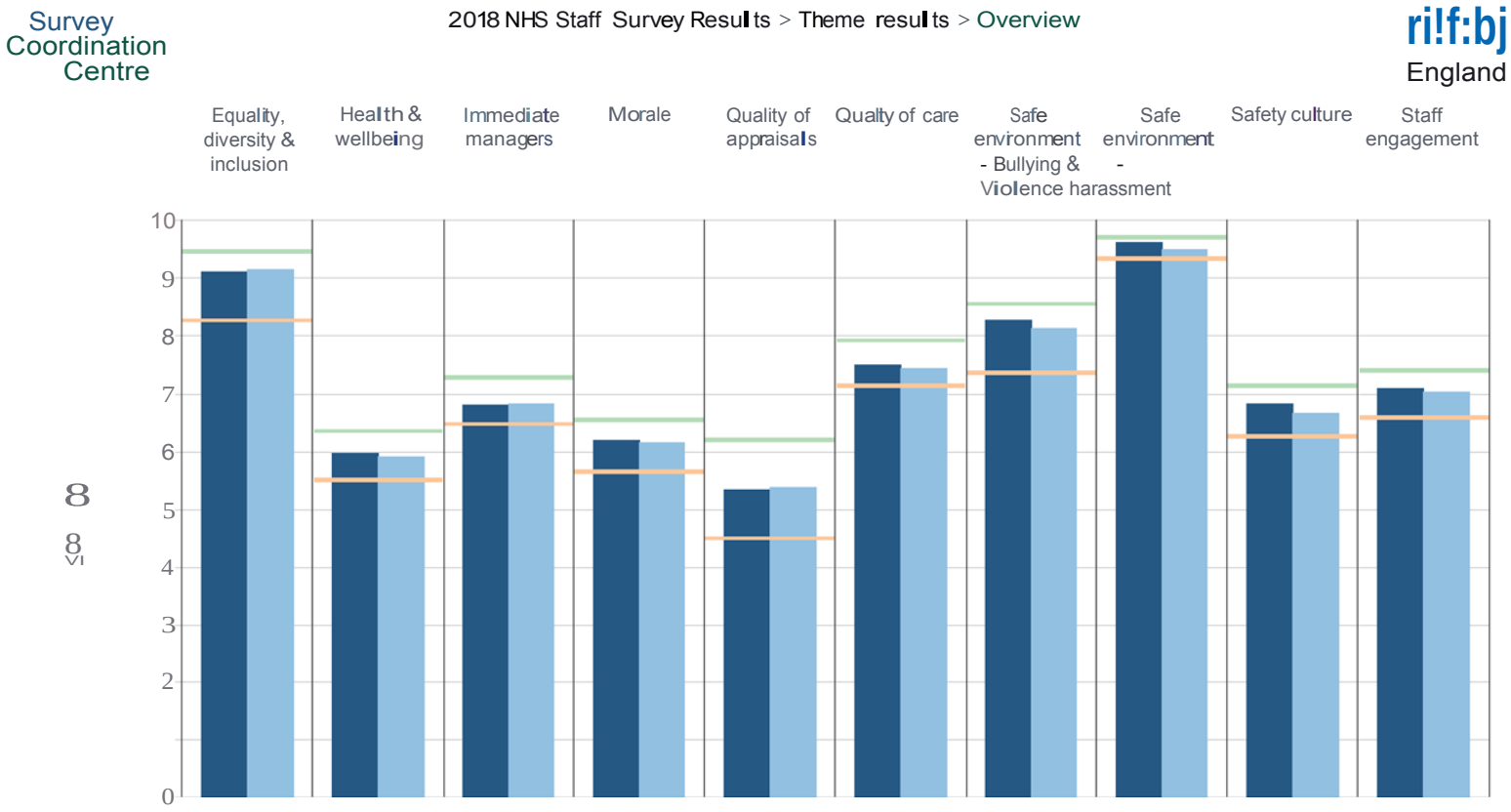
i). **Staff Engagement** particularly supporting staff to implement improvements
ii). **Quality of Appraisals**
iii). **Quality of Care**
iv). **Immediate Managers**
v). **Health and Well-being**
vi). **Equality, Diversity & Inclusion**

9.0 Recommendations

9.1 The Board of Directors are requested to note the strengths, improvements and areas for development.

9.2 Agree the priority areas for action as set out in section 9 with a mid-year review of progress against these actions to be undertaken by the HR Scrutiny Committee.

Appendix 1: Group Staff Survey Results by Key Theme, including sector comparison



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & Violence harassment	Safe environment -	Safety culture	Staff engagement
Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	9.1	6.0	6.8	6.2	5.3	7.5	8.3	9.6	6.8	7.1
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6
No.responses	6,827	6,883	6,917	6,790	6,011	6,089	6,844	6,829	6,842	7,016

Appendix 2: 2018 Staff Survey Results for Key Themes, by Hospital/MCS/Corporate area

	Equality, Diversity and inclusion	Health and Wellbeing	Immediate managers	Morale	Quality of Appraisal	Quality of Care	Safe environment - Bullying and harassment	Safe environment - Violence	Safety culture	Staff engagement
Group	9.1	6.0	6.8	6.2	5.3	7.5	8.3	9.6	6.8	7.1
CSS	9.2	5.9	6.7	6.2	5.2	7.4	8.4	9.6	6.9	7.0
Corporate	9.2	6.4	6.9	6.1	5.3	7.2	8.9	9.9	6.6	7.0
MDH	9.3	6.5	6.6	6.4	5.9	7.8	8.0	9.9	7.3	7.4
MLCO	9.1	6.0	7.0	6.4	5.5	7.7	8.5	9.7	7.0	7.3
MREH	8.8	5.8	6.6	6.1	5.1	8.0	7.8	9.8	6.9	7.0
MRI	8.7	5.8	6.7	6.0	5.6	7.5	7.8	9.3	6.7	7.0
R & I	9.1	6.1	7.0	6.3	5.4	7.8	8.7	10.0	6.7	7.3
RMCH	9.3	6.0	6.9	6.3	5.4	7.3	8.2	9.7	6.9	7.3
St Mary's	9.4	5.9	6.7	6.3	5.3	7.2	8.4	9.9	7.4	7.2
Trafford	9.0	5.5	6.6	5.9	5.4	7.3	7.9	9.3	6.8	6.7
W, W & A	9.1	6.0	6.9	6.2	5.1	7.7	8.1	9.5	6.7	7.2
Sector	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0

- 0.3+ higher than Group
- Up to 0.2 higher than Group
- Up to 0.2 lower than Group
- 0.3+ lower than Group

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss Toli Onon, Joint Group Medical Director
Paper prepared by:	Mark Lindsay, Assistant Director of Transformation
Date of paper:	25th February 2019
Subject:	Getting it Right First Time (GIRFT)
Purpose of report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	To share with the Board an update on how GIRFT is being adopted and embraced within MFT, and to provide details of recent and upcoming Clinical Lead visits.
Recommendations:	The Board of Directors is asked to receive the report and note the progress made with regard to embracing and embedding the GIRFT programme into core service improvement and delivery.
Contact:	Name: Mark Lindsay Tel: 0161 701 5778

1. INTRODUCTION

GIRFT is a national programme designed to improve medical care within the NHS by **reducing unwarranted variations,** by **sharing best practice** between trusts, by identifying changes that will help **improve care and patient outcomes**, as well as **delivering efficiencies** such as the reduction of unnecessary procedures and cost savings.

The national programme is made up of a series of **35 medical work streams**, each led by a prominent clinician chosen from the specialty they are reviewing. Each clinician heads a project to compile a data and insight driven report into their specialty, combining publicly available information, including **Hospital Episode Statistics (HES)**, other relevant registry or professional body data, and the results of a **questionnaire** issued to all the trusts being reviewed. The report will look at a wide range of factors, from length of stay to patient mortality, and individual service costs through to overall budgets.

MFT has been recognised as an exemplar site for how it is managing the GIRFT information and using it to drive improvements and a **case study is being written by the regional team**.

2. INTERNAL GOVERNANCE ARRANGEMENTS

The oversight of the GIRFT programme is via the Clinical Advisory Committee (CAC) chaired by the Group Medical Director. The Medical Directors provide oversight within each Hospital / Managed clinical service and the Transformation Team has a role as conduit between internal specialty teams and the national and regional GIRFT teams, leading on reporting to the Clinical Advisory Committee and facilitating specialty visits and other events as appropriate.

3. TRUST VISITS AND PROGRAMME ENGAGEMENT

The programme of specialty reviews began with surgical specialties and had recently transitioned into medical specialties. A number of visits took place in legacy organisations, however since October 2017, even though data packs have been produced based on historic, and therefore legacy organisations, combined specialty visits have successfully taken place (i.e. single meetings per specialty regardless of location). The Trust standard is now that joint visits (e.g. MRI/Wythenshawe) will take place as the norm.

Appendix 1 displays a table illustrating the level of involvement and progress to date against all GIRFT specialties.

The success of the GIRFT programme will ultimately be driven by embedding the process into business as usual. Steps taken to date include:

- Analysis of the programme to extract those with direct financial benefits, to report within 2019/20 hospital annual business planning opportunity packs
- Assessment of overarching (cross-specialty) improvement themes used to support construction of Clinical Standards Groups (CSG's) annual programmes of work.
- Specific Cardiothoracic Surgery and Cardiology work streams adopted by the Heart and Lung CSG.

4. IDENTIFIED BENEFITS TO DATE

Hospitals and Managed Clinical Services are not using the GIRFT information in isolation but GIRFT, along with model hospital data and benchmark data is being used to support the integration agenda and drive improvements. There have been a number of benefits reported to date:

General Surgery	Ambulatory care launched in MRI, 5 day service with consultant input	Reduction in overnight stays for simpler procedures
Trauma & Orthopaedics	Standardisation of implant purchasing within all sub-specialties	Financial savings in excess of £600k p.a.
Trauma & Orthopaedics	Low volume procedure standardisation – minimum annual requirement for hip and knee replacements for operating surgeons	Enabled pooling of patients to expedite surgical intervention
Trauma & Orthopaedics	Operating session times amended to better align to case timings	4 joint replacements per list
Trauma & Orthopaedics	Fractured neck of femur pathway improvements	Reduction in 30 day mortality to way below national average
Urology	Lithotripsy pathway improvements	No patients now waiting >4 weeks for surgery
Gynaecology	Cross-site working and clinical drive to improve pathways	Reduced time to treatment for surgical management of miscarriage

5. RECOMMENDATIONS

Members of the Board of Directors are asked to accept this report on how GIRFT is being adopted and embraced within MFT with examples of benefits to date.

APPENDIX 1

Specialty Progress as at 25th February 2019

Specialty	Pre-visit Questionnaire Completed	Trust Visit(s) Completed	Post-visit Recommendations Received/Reviewed	National Report Distributed	Data Refresh/Follow-up Visit	Notes
Breast surgery	✓	In progress – linked to regional theme 3 work				
Cardiothoracic surgery	✓	✓	✓	✓		Adopted by Heart and Lung CSG for implementation
Ear, nose and throat	✓	✓	✓			
General surgery	✓	✓	✓	✓		
Obstetrics and gynaecology	✓	✓	✓			
Ophthalmology surgery	✓	✓	✓			
Oral and maxillofacial	✓	✓	✓	✓		
Orthopaedic surgery	✓	✓	✓	✓	✓	
Paediatric surgery	✓	✓	✓			
Spinal surgery	✓	✓	✓	✓		
Urology surgery	✓	✓	✓	✓		
Vascular surgery	✓	✓	✓	✓		
Cardiology	✓	**6th June 2019**				
Emergency medicine	✓	✓	✓			
Endocrinology	✓	✓	✓			
Hospital dentistry	✓	**14th March 2019**				
Renal Medicine	✓	**17th May 2019**				
Imaging and radiology	✓	✓	✓			
Litigation	n/a	n/a Data pack received in 2018 by Legal Department	✓ Reviewed against GIRFT 5-point plan			Awaiting results of internal assessment
Surgical site infection audit	n/a	n/a Data pack received in 2018	✓ Notable lack of (meaningful) data			

Other/Specialty Visits Not Yet Commenced

Specialty	Pre-visit Questionnaire Completed
Plastic surgery and burns	**Appointed Clinical Lead: Mr. Ken Dunn – Consultant Plastic and Reconstructive Surgeon at the Wythenshawe Hospital, Manchester University NHS Foundation Trust.** He is Director of the Manchester Burns Service and has an honorary appointment to the Royal Manchester Children's Hospital.
Neurology	No trust visit but regional visit hosted by SRFT took place on 8th Feb 2019 – attended by MFT representative.
Outpatients	Not yet commenced – aligned to NHS Benchmarking for data collection purposes
Acute and general medicine	Not yet commenced
Anaesthesia and perioperative medicine	Not yet commenced
Dermatology	Not yet commenced
Diabetes	Not yet commenced
Gastroenterology	Not yet commenced
Geriatric medicine	Not yet commenced
Mental health	Not yet commenced
Rheumatology	Not yet commenced
Stroke	Not yet commenced
Trauma surgery	Not yet commenced
Intensive and critical care	Not yet commenced
Pathology	Not yet commenced
Medicines optimisation	Not yet commenced
Frailty and brain conditions	Not yet commenced
Policy levers	Not yet commenced
Procurement	Not yet commenced

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Margot Johnson , Executive Director of Workforce & OD
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	March 2019
Subject:	Board Assurance Framework (March 2019) and Proposed New 2019/20 BAF Format
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Ratify ✓
Consideration of Risk against Key Priorities:	**(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner)** In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	1. The Board of Directors is asked to accept the latest BAF (March 2019) aligned to the MFT Strategic Aims and Key Objectives for 2018/19 2. The Board of Directors is asked to ratify the New 2019/20 BAF Format following approval at the Audit Committee on 06.02.19
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (March 2019)

1. Background

Performance against the Board Assurance Framework (BAF) is reviewed at every formal Board of Directors via the Intelligent Board metrics. Significant risks to achieving the Trust's key priorities are reviewed and reported on at the Group Risk Management Committee (GRMC) and across other corporate Executive committees, where necessary, appropriate committees dependent on the risk rating.

The Trust Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

The full BAF (see **APPENDIX A**) is received and noted at least twice a year by the full Board of Directors whilst the Audit Committee reviews one or two BAF domains at each of its meetings throughout the year.

2. Review of the Strategic Aims

Key Priorities & Risks associated with the following Strategic Aims have been regularly reviewed at MFT Board Scrutiny Committees and the Group Audit Committee during 2018/19:

- *To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner*
- *To improve patient safety, clinical quality and outcomes*
- *To improve the experience of patients, carers and their families*
- *To achieve financial sustainability*
- *To develop single services that build on the best from across all our hospitals*
- *To develop our research portfolio and deliver cutting edge care to patients*
- *To develop our workforce enabling each member of staff to reach their full potential.*

3. Development of the Board Assurance Framework

Following a developmental review of Leadership & Governance arrangements using the Well Led framework during the Summer 2018, a Task & Finish Group consisting of Group Non-Executive Directors and Group Corporate Directors was convened during the Autumn 2018 to refine the format, content and operational effectiveness of the current MFT BAF.

Internal Audit (IA) also completed a review of the current MFT BAF on 21.10.18 and identified areas of good practice alongside areas where further refinements could be considered. IA graded the arrangements currently in place in relation to the MFT BAF as providing the Trust with "*significant assurance with minor improvement opportunities*."

The proposed changes / refinements to the existing BAF format (see **APPENDIX B**) were presented to, and, approved by the Audit Committee on 06.02.19 and is now recommended to the Board of Directors for ratification and implementation in Q1 2019/20.

4. Recommendation

4.1 The Board of Directors is asked to accept the latest BAF (March 2019) aligned to the MFT Strategic Aims and Key Objectives for 2018/19

4.2 The Board of Directors is asked to ratify the New 2019/20 BAF Format following approval at the Audit Committee on 06.02.19

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(March 2019)

Introduction

The Board Assurance Framework is one of the tools that the Trust uses to track progress against the organisation's Strategic Aims. As part of the development of the Board Assurance Framework each financial year, the Key Priorities for the year are identified and the potential risks to achieving these assessed for inclusion on the framework. As such, all risks on the Board Assurance Framework are set out under the Strategic Aims.

The Board Assurance Framework is based on seven key elements:

- Clearly defined Key Priorities for 2018/19 (aligned to the Trust's Strategic Aims)
- Clearly defined principal risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which these risks can be managed
- Potential and positive assurances that risks are being reasonably managed
- Board reports detailing how risks are being managed and objectives met, together with the identification of gaps in assurances and gaps in controls.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating

Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

Severity ↓	Likelihood →				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2: Slight	2 Very Low	4 Very Low	6 low	8 low	10 Medium
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5: Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

1	Strategic Aim: To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner

Principal Risk: 1. There is a risk that it will not be possible to access the resource needed to manage the acquisition and transformation of NMGH.	Enabling Strategy	Associated Committee
	Single Hospital Service	Board of Directors
	Lead Director	Operational Lead
	Director Single Hospital Service	Director Single Hospital Service

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	The process of acquisition may not be well managed, and/or the financial risks will be too great and the transaction will not be supported by the MFT Board.	Application of GM Transformation Funds to support effective programme management arrangements. Detailed Counterfactual Case developed (supported by Vendor Due Diligence in key areas) and discussions about financing now underway.	16 4x4	Resourcing of programme management functions outside MFT has been less well established. The outcome of the negotiations around financial support are not entirely within the control of the Trust.	GMHSCP and NHS I need to increase the pace of delivery in order to realise the projected timeline for the dissolution of PAHT. The content of the Counterfactual has now been accepted, but there is continuing uncertainty about the potential costs associated with addressing Estates and IM&T issues, and these may not be fully understood until Acquirer Due Diligence has been completed.	Continue to refine and apply the acquisition programme plan with milestones and reporting structures. Ensure the additional resources allocated to the GMHSCP/NHS I team are used to best effect. Continue regular "stock take" meetings between Chief Execs. Finance Working Group (sub-group of PAHT Transaction Board) to provide effective management of financial modelling.	Track record and experience gained from the CMFT / UHSM merger and full compliance with GMH&SCP governance arrangements and NHS I Regulatory processes. Development of direct dialogue with NHS I national team, with plans to progress discussions in February.	9 3x3

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Develop dialogue with key stakeholders on exceptional funding arrangements. Respond effectively to the Counterfactual case in the Strategic Case/Business Case development processes.	Group Chief Finance Officer	28/2/2019 31/3/2019	Board of Directors	Further to the Counterfactual modelling and Due Diligence on Estates and IM&T, obtain assurances and agreements from key stakeholders that are commensurate with the scale of the financial risks.	Size of acquirers' "ask" likely to make funding discussions challenging - discussions underway.

Principal Risk: 2. There is a risk that the timescale for completing the acquisition and transformation of NMGH will become excessively delayed.			Enabling Strategy			Associated Committee		
			Single Hospital Service			Board of Directors		
			Lead Director			Operational Lead		
			Director Single Hospital Service			Director Single Hospital Service		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **3x4**	The governance and management arrangements for the acquisition fail to deliver a timely outcome, and the problems currently being experienced by the PAHT services remain unaddressed and/or deteriorate further.	Agreed GM Programme Plan with multi-agency support, and greater clarity about roles of NHS I and GM H&SCP. Adequate resource identified to support the programme management of the NMGH acquisition process within MFT, and SHS Team working closely with existing management teams.	**12** **3x4**	Resourcing of programme management functions outside MFT has been less well established. The process and arrangements for the negotiations around financial support are not entirely within the control of the Trust.	GMHSCP and NHS I need to increase the pace of delivery in order to realise the projected timeline for the dissolution of PAHT. Challenges remain with the responses to the Vendor Due Diligence for Estates, particularly the level of assurance on remediation. Delays to commencing Acquirer Due Diligence on IM&T also has the potentia to influence the overall programme timeline Adequate progress needs to be made in the national discussions about exceptional funding.	Continue to refine and apply the acquisition programme plan with milestones and reporting structures. Ensure the additional resources allocated to the GMHSCP/NHS I team are used to best effect. Continue regular "stock take" meetings between Chief Execs. Finance Working Group (sub-group of PAHT Transaction Board) to provide effective management of financial modelling.	Track record and experience gained from the CMFT / UHSM merger and full compliance with GMH&SCP governance arrangement and NHS I Regulatory processes. Development of direct dialogue with NHS I national team, with plans to progress discussions in February. Transaction timeline reviewed by GM PMO (with in put from Acquirers) and revised target Transaction date of 31 March 2020 agreed, subject to satisfactory progress in discussions on funding.	**9** **3x3**

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Maintain a detailed NMGH acquisition project plan and milestones sensitive to MFT responsibilities, yet aligned to the PAHT Transaction Board Programme Plan for the dissolution of PAHT.	Director Single Hospital Service	On-going	Board of Directors	Clear milestones agreed and tasks/actions in place to deliver.	Programme management arrangements generally functioning well, but Finance work stream (Counterfactual development, funding discussions, etc) still likely to be the most significant rate-determining process.

Principal Risk: 3. There is a risk that decisions about NMGH service provision taken by Commissioners and/or SRFT in the period prior to acquisition could change the nature of these services and the role of NMGH within the Manchester healthcare system and the MFT service strategy.	Enabling Strategy	Associated Committee
	Single Hospital Service	Board of Directors
	Lead Director	Operational Lead
	Director Single Hospital Service	Director Single Hospital Service

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
9 3x3	The effect would be potentially to fragment or destabilise services and reduce the potential Single Hospital Service benefits of acquiring NMGH .	MFT's membership of the GMHSCP Transaction Board and sub-groups. MFT's involvement in the NM Strategy Board, NM Master Planning group and other subcommittees. Also, MFT involvement in other GMHSCP forums (e.g. Theme 3, SPB, PFB). MHCC's membership of North East Sector Board. Stocktake of existing NMGH services that has been carried out, and Pennine Transaction Operational Group (PTOG) formed to provide a forum for potential changes to NMGH services to be discussed directly between Chief operating Officers. MFT service strategy development programme takes account of NMGH services. MFT / MHCC working relationship.	6 3x2	SRFT is currently managing services at NMGH and working with some Commissioners to make decisions about service provision on the NMGH site. Decisions about NMGH are not totally within the control of MFT.	Lack of visibility of changes being made at service level if these are not communicated at PTOG, NM Strategy Board, or through the PAHT Transaction Board Commissioning sub-group.	Feedback from clinical teams at MFT and PAHT, providing routes to communicate any service changes to MFT corporate level if needed. Increased understanding of current NMGH service provision through service familiarisation and categorisation process.. MFT sighted on SRFT proposals for PAHT Financial Recovery Plan (through dialogue between DoFs). PAHT Transaction Board Commissioning Strategy sub-group assessment and control of any changes proposed at NMGH. Pat Crowley appointed as non-conflicted Exec Director, with ability to take an independent view of any contentious issues.	Agreements that April 2017 should be the baseline for the NMGH services for the purposes of the transaction, subject to PAHT Financial Recovery Planning process. Successful action by MHCC to limit consideration of "alternative options" by North East Sector Commissioners, with this position now being agreed through Commissioning Strategy Sub Group. PTOG now providing route for potential changes to operational services to be discussed.	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continue to utilise PTOG and Commissioner routes (NES Board, NMSB, etc) to strengthen intelligence and influence. Build links with NMGH clinical community and wider stakeholders.	Director Single Hospital Service	On-going	Board of Directors	Better information on which to build arguments in the service disaggregation process, and challenges to any proposed services changes at NMGH.	Progress made eventually with Counterfactual, drivers of the deficit, and Estates Due Diligence, but lack of clarity remains around Financial Recovery Plan and the operational response to the Estates Due Diligence findings.

Principal Risk: 4. There is a risk that the proposed transaction could create uncertainty amongst staff at NMGH and this could exacerbate recruitment and retention difficulties, particularly if the transaction process is protracted.			Enabling Strategy: Single Hospital Service		Associated Committee: Board of Directors		
			Lead Director: Director Single Hospital Service		Operational Lead: Director Single Hospital Service		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	If recruitment and retention difficulties are exacerbated this could mean that MFT would acquire an organisation with significantly worse staff shortages.	MFT and SRFT both recognise the issue and will work together to mitigate the risk. As a first step joint recruitment activity across MFT and NMGH for consultant medical staff in hard-to-fill services has already commenced and will continue. Communications and engagement work with NMGH staff has been ongoing since Project 1 and will continue for the duration of Project 2. Partnership arrangements (e.g. staff side) are currently being reviewed to take account of NMGH requirements.	16 4x4	Greater Manchester Health and Social Care Partnership (GMHSCP) has over-arching responsibility for communications about the dissolution of PAHT, therefore MFT does not have complete control over the content or timing of communications messages. In addition, communications need to be agreed across multiple partners which can cause delays.	Generation of key messages for staff (and other audiences) following Transaction Board meetings is not working effectively. Development of communications materials (eg Frequently Asked Questions) is slow. Arrangements for engaging with key stakeholders are not effective.	Production of more extensive communications materials. Creation of a tri-partite workforce partnership forum with trade unions, MFT and SRFT. Promotion of NMGH/MFT as an attractive place to work and learn. MFT has strengthened its visability on the NMGH site through visits from Clinical Executives and Clinical Due Diligence activities, in addition to established participation in Team Briefing sessions	Completion of the transaction Project Plan to inform communication and engagement activity with NMGH staff. Completion of a transaction communications plan signed-off by all parties. Noting GM lead responsibility, maintain MFT focus on developing comms opportunities with NMGH staff and other stakeholders. Continue to maximise opportunties for collaborative recruitment.	**12** **4X3**

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continue to engage effectively with GMHSCP and other partners in the transaction to influence key decisions. Establish and strengthen relationships with trade unions and SRFT..	Director Single Hospital Service	Ongoing.	Board of Directors	Solid information about the transaction to convey to NMGH staff and agreed mechanisms for communication and engagement.	Progress with staff communications activities continues to be too slow and too limited.

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

Principal Risk: Underachievment of the A&E / Urgent Care Waiting Time standard could impact on clinical outcomes and patient experience and affect the Trusts reputation (001707)	Enabling Strategy	Associated Committee
	Hospital Transformation Programme	Hospital Boards
	Lead Director	Operational Lead
	Chief Operating Officer	Director of Performance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact /Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 4x5	Clinical Outcomes	.The Accountability Oversight Framework (AOF) .Board Assurance Report .Reporting to the Quality and Scrutinity Committee. .Board of Director receive routine information on operational performance, transformation improvements and system wide resilience to gain assurance of patient timely care and safety. .GM Urgent Care Board and NHSI oversight. .Manchester Urgent Care Transformation Board and supporting .Operational De;ivery Groups. .LHE Operational Pressures Escalation Level reporting and teleconferences .GM System Escalation Reporting - Tableau .Daily SITREP reporting. .Patient Flow Boards at MRI and Wythenshawe Hospitals. .Transformation review of urgent of urgent care at Wythenshawe and MRI Hospitals in October 18, with a further re-audit in February 19. .Weekly governance assurance arrangements in place for hospitals / MCS underperforming against agreed trajectory.	20 4x5	.Inability to secure professionally qualified workforce .Demand levels in excess of planned levels .Mobilisation of OPEL response across the economy .Reliance on partners to mobilise winter schemes and increase winter capacity.	Factors which can cause significant and sustained surges in demand	Performance reporting to Board of Directors.	Risk Management Committee. Quality and Performance Scrutiny Committee. Board of Directors	**12** **3x4**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
.MRI/WTWA have improvement programmes in place, focused on actions identified from the urgent care reviews undertaken in Q2. MRI - Actions in MRI are focused on reducing waiting time and mitigating Minors breaches. Wythenshawe - Actions focus on reducing delays within the ED department. .Weekly Hospital trajectories and breach tolerance in place aligned to 90% standard, and recovery in Q4 Weekly assurance meetings in place .All Hospitals providing Capacity plans 19/20 MLCO meeting weekly with Hospital sites to focus on reducing stranded patients with agreed targets in place. .Increased Primary Care Streaming, MRI. GP front door Wythenshawe, Additional GP RMCH .Accessing external support from ECIST with regards to: Wythenshawe corridor care and DToCs/LoS reviews, and MRI LoS/dischare processes .Capital upgrade to Wythenshawe complete, MRI schemes progressing through project RED, PED capital scheme at the design phase. .Implementation of GM standards for patient choice, trusted assessor and Discharge to Assess. .Participation in GM Action on A&E events. .Paticiptaion in GM - Out of Area Discharge Workshops. Hosting final GM workshop 20.02.19	Clinical Divisions / Health System	on-going	Quality & Performance Scrutiny Board of Directors	Improved Patient Flow / Greater Seasonal resilience	December MFT delivered 84.56%, and a Q3 performance of 84.19%. Improving MFT regional ranking from rank 6 in October to rank 2 in December, achieving +2.56% higher than GM. Q4 performance remains challenged which is in line with the national and regional position, with MFT performance of 81.93% in January. Q4 recovery trajectory and escalated oversight/ssurance arrangements with the Group COO and Hospital CEOs have been instigated as a result. MFT continues to work with system partners to increase flow and reduce stranded patients to agreed threshold.

Principal Risk: Underachievement of the Diagnostic 6 Week standard could impact on clinical outcomes and patient experience, and affect the Trusts reputation (001701)			Enabling Strategy			Associated Committee		
			Transformation Programme			Transformation Programme Board		
			Lead Director			Operational Lead		
			Chief Operating Officer			Director of Performance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact /Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Clinical Outcomes	Accountability Oversight Framework Board Assurance Framework and Board Assurance report provides group monitoring and governance. Patient Access Policy Hospital/MCS operational KPI meetings Recovery trajectories in place for risk tests. Monthly forecasting in place for all sites	16 4x4	Demand in excess of planned levels National cancer campaigns Patient Choice Failures in equipment Workforce pressures	Reliance on private sector GM capacity constraints across a number of providers	Performance reporting to Quality and Performance Scrutiny Committee and Board of Directors.	Risk Management Committee. Quality and performance Scrutiny committee. Board of Directors	**12** **4x3**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
.Recovery trajectories refreshed in January 19 .Additional capacity through the transfer of Adult Endoscopy capacity to Trafford CCG commissioned community services from Fenruary 2019. .Capital works completed securing JAG accreditation and providing additional capacity. .Paediatric MRI - additional anaesthetic and radiology sessions being secured. . Interim additional waiting list sessions being undertaken. .Implemntentation of the business case for the 3rd MRI scanner	Clinical Services	Trajectory to meet 1% standard in Q3 2018/19	Quality and Performance Scrutiny Committee	Waiting times delivered	In year there has been improvement in performance, with paedaitric endoscopy no longer a concerm. However due to continuing demand pressures, coupled with workforce and capacity constraints, the level of improvement is not yet sustainable. December delivery of 2.37% is better than the national picture of 3.1%. A number of hospitals/MCS within te egroup are dleivering the 1% standard, with challenges remaining in adult endoscopy and paediatric MRI which are a risk to Q4 performance.

Principal Risk: Underachievement of the Cancer Waiting Time standards could impact on clinical outcomes and patient experience, and affect the Trusts reputation (001708)			Enabling Strategy: Hospital Transformation Programme				Associated Committee: Hospital Boards	
			Lead Director: Chief Operating Officer				Operational Lead: Director of Performance	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Clinical Outcomes	.Accountability Oversight Framework .Board Assurance Report .Group Cancer Committee, underpinned by Hospital/MCS Cancer Boards .Patient Access Policy .Cancer dashboards in place .Group and Hospital PTL meetings and management of patients through the pathway. .Executive oversight of PTL at MRI with dedicated Executive Lead .RCAs undertaken for all breach patients .Harm reviews undertaken for any patient +104 days on a pathway .Escalation process in place to ensure timely action of patients along the pathway. .GM Cancer Access Policy updated and signed off by NHSI in February 18. .Trust Capacity Group receives risk assessment/capacity plans for national cancer campaigns to mitigate demand increases. .Trust compliant with the 10 High Impact Actions for Cancer .Trust Action plan in place, which has been externally assured by NHSI/GM Partnership	16 4x4	.Pathway management across multiple Trusts. .Patient choice .Demand in excess of planned levels .Critical care constraints affecting elective activity . Diagnostic capacity pressures impacts on pathways.	.Adherence to GM developed cancer pathways .Surges in demand. .Changes to national cancer standard, breach allocation.	Performance reporting to Board of Directors. Oversight of performance delivery at the Trust Cancer Committee chaired by the COO Performance oversight through local Hospital Executives.	Risk Management Committee. Quality and performance committee. Cancer Board	12 3x4

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
.Cancer site level action plans - focused on increasing capacity for first appointment, diagnostic scanning and reporting .Hospital Cancer Boards and operational KPI meetings undertake local actions in response to capacity pressures. .Weekly monitoring/management of individual patients that are +30 days on the PTLs . Focusing on the implemntation and standardisation of best practice pathways. i.e. LGI and Lung .CSS focus on pathology reporting <7 days MRI .Heightened performance reporting in place from Q4 to support operational oversight and management . Exceptional meeting of the MFT Cancer Committee in January, with presentations from clinical leads and actions being taken as a result.	Hospital Executives, Corporate Performance Team	Q4 18/19.	Cancer Committee	Delivery of Cancer Standards	MFT has strong performance against the majoirty of national access standards, although performance against the cancer 62 Day standard is challenged in the MRI Hospital and SMH, with strong performance at WTWA. The Trust reported 80.85% against the 85% standard for Q2. Trust performance mirrors the national and regional position both of which are unerperforming against the 62 day standard. An exceptional meeting of the Trust Cancer Committee took place in January to bring clinical teams together to review the cancer pathways and best practice. NB. national changes to the reallocation of treatment and breaches is likely to impact on provider performance from Q3, despite no real change to pathways, and is a risk to MFT.

Principal Risk: Underachievement of the Referral To Treatment 18 week standard could impact on clinical outcomes and patient experience, and affect the Trusts reputation (Risk 001493)			Enabling Strategy			Associated Committee	
			Performance Management			Quality & Performance Scrutiny	
			Lead Director			Operational Lead	
			Chief Operating Officer			Director of Performance	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 5x4	Clinical Outcomes	.Governance and Oversight provided by Accountability Oversight Framework, .Board Assurance Framework and exception reporting. Patient Access Policy .Weekly RTT Task Force in place chaired by Deputy COO and .Director of Informatics, with supporting action plan and commissioner support in place, .PMO approach established to manage 52+ weeks and tactical solution to non compliant PAS .Hospital Boards and local KPI meetings to manage performance and capacity risks. .Capacity and Demand planning in progress 19/20 .Hospital Data Quality Audits continue, with planned audits of all waiting lists. .RTT Trajectories in place for all Hospitals/MCS	20 5x4	.Commissioner decisions around alternate providers .Non compliant RTT PAS system. .Outsourcing capacity and capability of additional capacity.	Robustness and quality of commissioned alternatives	Performance reporting to Board of Directors. Trust Performance and Delivery Assurance Group.	Risk Management Committee. Quality and performance Scrutiny Committee.	16 4x4

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
.RTT Task force focusing on long wait patients, chaired by Deputy COO and Chief Informatics Officer, in place. .RTT PMO approach established from September . Planned upgrade of PAS to take place in Q1. .Additional validation teams in place supporting Hospital teams .Monthly data quality audits are on-going. .Delivery of Hospital transformation and capacity plans. .Additional endoscopy capacity secured in community mobile units from February 19. .Monies available to commission private capacity outsourcing until 1st April 19. .ERS roll out, transparency of polling range .Hospital Site PTL meetings continue to ensure the effective management of waiting times. .Standard Operating Policies .Participation in GM master classes for RTT .Participation in NHSI Demand and Capacity modelling training.	Hospital Sites	On-going	Quality & Performance Scrutiny	Activity Levels Delivered and Waiting times improve	MFT reported performance of 87.75% in December reflecting tactical actions taken for closed pathways, and reflects the national position of, 87.3% November (latest reported). The Trust has seen an increase in the RTT waiting list, the national focus for 2018/19 is to maintain the waiting list size in March 19 compared to the previous year. The Trust is taking additional action in Q4, working with Commissioners on securing additional activity and demand management Oxford Road Campus has achieved the trajectory of 0 +52 breaches from Septmeber. Wythenshawe Hospital reported 22 +52 highly complex DIEP patients in December.

Principal Risk: If mortality rates are not below 100 before rebasing then this may indicate poor quality outcomes and will impact negatively on organisational reputation (2848C)	Enabling Strategy	Associated Committee
	Mortality Review Strategy	Mortality Review Group
	Lead Director	Operational Lead
	Medical Directors	Associate Medical Director / Director of Clinical Governance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 4x5	Poor patient outcomes Reputational impact Associated business continuity	Hospital/MCS Structure CD Programme and leadership development Standards of clinical care Pathways in place NICE/NCEPOD monitoring High Level Investigation thematic reviews Mortality Review Groups in place Coding differences betweeen the larger sites under review and being standardised Revalidation and appraisal process Patient safety projects Clinical audit processes Structured Judgement Review training undertaken	**12** **4x3**	Coding inaccuracies Adherence to record keeping standards Gaps in compliance with new National guidance	Lack of confidence in accuracy of coding information	Intelligent Board Framework Mortality dashboard Benchmarking using NHSIC data Further clinical audits on pathways Health Education North West visit data Internal Audit Central Portal GMC survey data Monthly CQC feedback Full evaluation of Leadership schemes AOF	Aqua Regional Report on Mortality Current Group SHMI and HSMR ≤100	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Development of a joint work programme by the Clinical Governance Team the Informatics Team and the OD&T Team on the quality of the patient record. See risk MFT/000748 for detailed action. Work underway to meet the requirements of the new National guidance. Standardisation of approach across the Group - use of the structured judgement review Establishment of a separate review panel for deaths of patinets with a recognised Learning Disability Work underway to establish the Medical Examiner role	Rachel Jenner / Nicky Anders- Associate Medical Directors Sarah Corcoran - Director of Clinical Governance Alison Daily - Director of Informatics Dave Pearson - Chief of Staff	2019	Quality and Safety Committee	SHMI <100 HSMR <100	SHMI ≤100 HSMR ≤100 Learing Disability Deaths review completed

Principal Risk to Key Priority:	Failure to deliver the Medical Workforce Projects	Enabling Strategy		Associated Committee	
				HR Scrutiny Committee	
		Lead Director		Operational Lead	
		Medical Directors		Dave Pearson/Claire Macconnell	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 4x3	Failure to deliver the Medical Workforce projects could lead to patient safety risks associated with inability to fill medical shifts, loss of control of agency and internal locum spend, and impact on Turnaround	1.Group Executive Sponsors of Medical Workforce Workstream 2. Hospital management teams 3. Accountability Oversight Framework (AOF) 4. Job Planning Tool implementation and outputs 5. 7DS Group and 7DS RAG-rated Action Plan 6. 7DS Joint Assurance Group (Central and Wythenshawe) 7. HR Scrutiny Committee oversight 8. Finance Scrutiny Committee oversight 9. LNC liaison 10. Turnaround Committee 11. Medical Staffing Costs monthly dashboard 12. Internal Locum Dashboard (eWIP) 13. Top Earners (Additional Shifts) Report 14. WAVE monitoring 15. NHS I Weekly Agency Report 16. Trackers to underpin locum and agency use within the Divisions 17. MIAA Audit Recommendations	12 4x3	Consistency in approach of Hospitals/ Divisions Consistency in approach at regional and national level (Different levels of engagement displayed by Hospitals/ Divisions) Consistency around key Medical Workforce processes (e.g. Annual Leave, Agency approval process) Differing approaches to management and reduction of locum and agency spend across Hospitals/ Divisions Gaps in the workforce information recorded and monitored by Hospitals/ Divisions;and lack of tools to effectively manage available workforce information No prompts in the paper patient record - EPR would resolve this (7DS) Transition to new Hospital Management Structures and dissolution of MWP Team	Assurance that key information is cascaded appropriately within Hospitals/ Divisions (e.g. from Senior Management Teams down) Robustness of Job Planning Tool and ensuing reports Difficult to qualify/ quantify impact of Medical Workforce projects on Turnaround MWP Team will cease to exist in its current format	CEO Forum reports Regular updates to Joint Group Medical Director and Group Director of Workforce and OD HR Scrutiny Committee progress reports NHSE Monitoring Reports Turnaround Control Group	Steady progress to 100% Consultant Job Plans available via Job Planning tool and evidence of annual review Reducing Locum/ Agency Spend Visible improvement in each 7DS Self Assessment Survey cycle (currently Spring) Tangible progress/ completion against recommendations set out in the MIAA Audit of Locum and Agency Staff	6 3x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Update
On-going Actions from August and October BAF Documents					
Provide training (Job Planning Tool; Team Job Planning)	Alison Wake, Ash Sukthankar	Q1	- CEO Forum - HR Scrutiny Committee - Turnaround Control Group - Quality and Performance Scrutiny Committee - Board of Directors - GMB - Operational Workforce Committee	All Consultant Job Plans are input to the Job Plan tool; and approved Divisions are engaged in Team Job Planning; and can use reports produced by the Job Plan tool to inform changes and improvements for the next job planning cycle	94% of consultants at Oxford Road a job plan created on the system, with the majority of those outstanding being new starters to MFT. A number of Team Job Plan training sessions have been successfully run on the Oxford Road campus; similar sessions have now been offered to Wythenshawe sites, to be arranged. Following the merger of hospitals there were two electrnic job planning systems at the legacy hospitals. A simgel system has been chosen so that all job plans for MFT will be on a single platform and this is being rolled out over 19/20
Provide regular job plan status reports to Divisions	Cameron Chandler	On-going		Divisions are well-informed regarding the progress of input and approval of Job Plans	Weekly reports are sent to ORC Hospital /MCS Medical Directors and HR Directors with the overall status of job plan progress and the status of each individual clinician in their Hospital / MCS. Thiis process will be reaplced once the move to the new platform is complete
Coordinate MIAA audit of processes for booking locum medical staff; and work with Divisions to standardise processes and implement recommendations from this audit	MVP Team	Q2/3		Reduction in locum and agency spend following the introduction of improved processes and/or replication of areas of good practice Trust-wide	MIAA Report and recommendations have been sent to each Hospital and the actions are being managed accordingly in new hospital structures. New electronic system is being introduced across Trust so that all medical agency bookings are electronic. Suite of reports being generated to help manage agency action plans. A new audit has also been commsioned via the Trust Internal Audit team so that progress can be asseseed
7DS Autumn Survey (September)	Divisions, supported by Cameron Chandler	Q2		Improvement in Trust-wide and individual Division results from the Spring Survey	A self-assessment for Standard 2 took place for all relevant emergency admissions during the period 14 – 20 November 2018. This was predominantly undertaken prospectively with a retrospective audit of specialties not sufficiently included in the original sample. 707 admissions were audited in total, representing 57% of the total emergency admissions, compared to 440 admissions audited during the last survey (April 2018). Failures underwent a re-audit process to validate the data. Compliance has dropped from 90% to 81% and analysis on the areas of non-compliance is taking place.
Review Allocate products for Job Planning; Appraisal; and Medics' rostering: - Demonstrations of products - Commercial considerations (e.g. procurement, costs, SHS) - Development of Business Case	MWP Team	Q2		A robust Business Case is developed to support the introduction of a suite of tools that will provide a more detailed understanding of the medical workforce, enabling better management of this resource	Business Case Approved 26.02.18. Work has commenced on rolling out Allocate to the Oxford Road Campus for the job planning and medic rostering modules. These are currently in place in Wythenshawe . Work is being undertaken to align the job planning language across all Hospitals / MCSs.
Work with Divisions to begin the next cycle of Job Planning; and monitor progress	MWP Team	Q2/3		Divisions use Team Job Planning to update existing Job Plans and approve all Job Plans by close of 2018/19	Hospitals/ Divisions have been sent generic WAVE milestones in line with national job planning guidance as part of their Turnaround Opportunity Pack for Medical Workforce. These milestones have now been transferred to the individual hospital medical workforce boards for delivery
Support Divisions to identify persistent gaps in Junior Doctor Posts	MWP Team	Q3		Divisions are able to understand any recurrent or persistent gaps in staffing, and identify the best means of addressing these gaps (e.g. re-modelling, making posts more attractive through rotations etc)	Hospitals are now managing this workstream via their individual medical workforce boards. The Group Medical Education team have been successful in application for Tier 5 employment status for international doctors which will allow the development of Group wide medical rotations
Work with Divisions to establish Local Consistency Panels for Job Plans	MWP Team	Q3		Each Division has a Local Consistency Panel that is able to resolve discrepancies and locally mediate any disputed job plans	All hospitals are in the process of setting up consistency panels as part of their medical workforce boards
Create Transition/ Handover Pack for Hospitals/ Divisions	MWP Team	Q4		Hospitals/ Divisions are well positioned to pick up the Medical Workforce agenda, and have clarity regarding the escalation and Group assurance routes	Completed 27.02.18
Handover meeting with the Medical Workforce Workstream Executive Sponsors	All Hospitals/ Divisions; MWP Team	Q4		Hospitals/ Divisions outline how they will pick up the Medical Workforce workstream agenda, and provide assurances to the Group Executive Sponsors of their commitment to deliver this workstream	Completed 27.02.18

Principal Risk: If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm			Enabling Strategy: Safeguarding annual plan			Associated Committee: Safeguarding Committee	
			Lead Director: Chief Nurse			Operational Lead: Group Deputy Chief Nurse	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
15 5x3	Adults and children at risk of abuse or neglect may come to harm	1. Safeguarding Governance Structures in place. 2. Safeguarding policies and procedures. 3. Safeguarding Teams actively support staff. 4. Safeguarding lead Director oversees delivery and monitoring of annual safeguarding work programme and Assistant Chief Nurse for Safeguarding post in establishment. 5. Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/MLCO. Medical Safeguarding Leads identifed for all hospitals/MCS/MLCO. 6. Named Doctors and Named Nurses in place to provide professional support and advice. 7. Senior representation at MSCB and MSAB and underpinning Leadership/Executive Groups to support statutory duty to cooperate. 8. Safeguarding adults and children's training programme in place and updated yearly as per Intercollegiate guidance to ensure up to date and relevant information is contained and staff have contemporary safeguarding information to support practice, and learning from SCRs/SARs/DHRs disseminated through safeguarding leads. 9. Safeguarding Supervision in place and monitored. 10. Learning Disability flag in place to alert LD Specialist Nurse to review patient (ORC). 11. Hospital/MCS safeguarding assurance processes in place to assess compliance with CQC requirements. 12. Incident reporting of non attendance by Trust staff at statutory child protection meetings in place. 13. Reports provided to statutory meetings if staff are unable to attend. 14. Policies contain the most up to date information and guidance for the Trust to follow to ensure patients and clients at risk of abuse and neglect are protected. 15. Child Protection Information Sharing System (CP-IS) in place in Paediatric ED, Eye and Dental emergency Departments, Wythenshawe ED, MRI ED and walk in centre and Gynaecological urgent care and ready to go live in Trafford UCC to alert Local Authorities to a child's ED attendance. Implementation of CP-IS progressing for MREH Emergency Eye Dept., Dental Hospital, Trafford UCC and Emergency Gynaecology Unit.	**10** **5x2**	1. Delays in Best Interest assessment and DoLS authorisation by Local Authority due to insufficient capacity to respond to high number of DoLS applications. 2. Inconsistent quality of MCA assessment and DoLS applications. 3. Not all hospitals achieve full compliance with required training attendance. 4. Limited LD specialist nurse capacity, no provision for WTWA and no provision to cover leave. 5. Limited MH Specialist capacity	1.Inconsistent compliance with training requirments 2.Invitations to case conferences and strategy meetings are not received at a single point therefore there is no single monitoring system for the Trust. 3. Prevent training compliance below target.	1. Incident Data. 2.Training attendance data. 3. Hospital/MCS/MLCO Assurance self-assessments. 4. DoLS/MCA Assessment Records. 5. Annual Audit Programme Outcomes. 6. External Review (Ofsted/CQC inspection, Section 11 Audit, CCG review of safeguarding and LAC provision) 7. Case conference/strategy meeting attendance records 8. Post Transastion Integration Plan to integrate safeguarding function.	1. Annual Safeguarding Report to Board of Directors. 2. Hospital/Managed Clincal Service annual Safeguarding Work Programme, monitored by hospital/MCS safeguarding groups and repored to Safeguarding Committee chaired by Chief Nurse. 3. Hospital Management Team Safeguarding Assurance meetings (re: compliance with CQC regulations) with Group Deputy Chief Nurse, Assistant Chief Nurse (Safeguarding) and NED with safeguarding lead - reported to the Safeguarding Committee. 4. Completion of SCR actions - reported to the Safeguarding Committee. 5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. 6.Submission of MSAB Annual Assurance statement and supporting evidence.	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Deliver annual safeguarding work programme	Head of Safeguarding	31/03/2019	Safeguarding Committee	Safeguard people at risk of abuse or neglect	1. MFT Safeguarding Committee, chaired by Chief Nurse, established and meeting quarterly. Sub-Group structure ratified by Safeguarding Committee and sub-groups with membership from hospitals/MCS/MLCO and corporate services meeting regularly. 2. Safeguarding PTIP completed to integrate policies, training and practice across MFT. 3. 2018/19 Annual safeguarding work programme progressing. 4. Single Prevent training programme implemented across MFT. 5. 2018/19 Safeguarding Assurance process completed with all hospital/MCS/MLCO management teams and outcomes will inform annual safeguarding work plans. 6. DoLS point prevalence study conducted in Q2 and actions identified to ensure DoLS applications are made appropriately. MSAB aware of delays in Best Interest assessment and DoLS authorisation. Following on from the Law Commission's recommendations to make changes to the DoLS process, the Mental Capacity (Amendment) Bill was introduced to the House of Lords on 3 July 2018 and has been progessing through parliamentary processes; it is scheduled to return to the House of Lords on 26 February for consideration of Commons amendments. 7. Positive section 11 Peer review meeting held with MSCB. 8. Adult annual assurance statement completed and submitted to MSAB with positive feedback. 9. CQC review of safeguarding children and looked after children services in Manchester conducted and report received in January 2018, highlighting many areas of good practice. Action plan progressed to address recommendations and monitored by Safeguarding Committee. MFT continues to work with partners on the development of revised multi-agency safeguarding arrangements in response to legislative changes. 10. Governance structure established for Mental Health Act (MHA) through the Safeguarding governance structure and expansion of MHA administration capacity progressing. MH Policies ratified for MHA and drafted for suicide prevention and care for patients who experience disturbed behaviour due to mental health conditions. Ligature risk assessment work conducted across the Trust. Mental Health Champions being identified across clinical areas. 11. Self assessment completed against NHSI Learning Disability Improvement Standards for NHS Trust (published in June 2018) and LD workplan devised. 12. New Assistant Chief Nurse (Safeguarding) appointed. 13. Competencies for safeguarding adult training stipulated by the Intercollegiate Guidance mapped to staff and additional level 3 training programmes established to meet increased requirements.

Principal Risk: If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised			Enabling Strategy			Associated Committee	
			Nursing and Midwifery Retention Strategy and Recruitment Work Programme			Nursing, Midwifery& AHP Professional Board and Human Resources Scrutiny Committee	
			Lead Director			Operational Lead	
			Chief Nurse			Corporate Director of Nursing	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	Compromised care and patient experience. Poor retention of nursing and midwifery staff.	1. Nursing, Midwifery and AHP Professional Board, Clinical Risk Management Committee and HR Scrutiny committee monitor controls in place 2. Domestic recruitment 'Proud to Care' campaign continues to attract applicants. 3. Candidate engagement processes established to maintain candidate interest in role from application to commencing in post. 4. Regular reports from recruitment management system to identify delays in process and enable actions to be taken 5. Programme of international recruitment from EU, India and UAE is in place 6. Nursing and Midwifery retention strategy 7. Monthly ESR reports established to monitor turnover and new starter activity 8. Acuity and dependency monitoring undertaken in all areas where validated tool is available 9. Developed reporting mechanism from e rostering and safe care system to enable effective management of resource in line with patient acuity 10. Implemented revised nursing and midwifery workforce reporting processes aligned with finance and workforce planning data 11. Board support to recruit to turnover for band 5 and band 2 roles within the Trust 12. Analysis of integrated governance information such as complaints and incidents against staffing levels	**9** **3x3**	1. Current recruitment process provides limited assessment for values and behaviours 2. Use of E roster and safe care in real time still being embedded within all clinical areas. 3. Brexit and regulatory changes to English language requirements have led to a marked decline in the number of EU nurses applying to work in the UK which has an impact on supply.	1. Ability to reduce number of vacancies against the national workforce supply issues in terms of qualified nurses and midwives.	1. Recruitment campaigns resulting in substantive appointments of both nurses and midwives 2. Unify data reported from Health Roster to ensure accuracy of planned and actual staffing data 4. Regular reports from recruitment management system to identify delays in process and enable actions to be taken 5. Reduced turnover and improved retention rate in band 5 roles. 6. Time to fill reporting by recruitment phase to support continuous improvement cycle 7. Reduced overall qualified vacancy levels and vacancy levels of staff nurse (band 5 roles) since August 2018 8. E Rostering and Safe care module used effectively by all wards and departments 9. Control and challenge meetings implemented in all areas to ensure effective rostering of staff and appropriate use of temporary staff 10. Programme of work in partnership with HR to reduce nursing and midwifery absence rates	1. Bi annual Safer Staffing reports to Board of Directors. 2. Nursing and Midwfery vacancies and turnover reported agaisnt Hospital/MCS AOF KPI's 3. Reports to Group Management Board, HR Scrutiny Committee, Professional Board, Risk Management Committee. 4. Establishments reviewed as part of annual budget setting process or when there are any significant changes in service or patient cohort. 5. Acuity and dependency monitoring undertaken in all areas where a validated tool is available. 6. Recruitment & Retention Strategy to be developed in partnership with HR and through trust wide engagement to reflect needs of new organisation 7. The Trust is part of GM pilot for trainee nursing associate roles.	**6** **2x3**

Monthly

Key Actions	Responsibility	When	Monitoring Committe	Progress Evaluation
Please see actions detailed in Trust Risk Management Report (risk 4117C) Revision of nursing and midwifery recruitment plans and retention strategy.	Nursing and Midwifery Workforce Development Group	Sep-19	Nursing, Midwifery and AHP Professional Board	Programme of recruitment events ongoing to support attraction of staff. There is a calander of events arranged for the next 12 months to support Trust wide recruitment events across the Trust including specific events for RMCH and SMH Recruitment and retention schemes have resulted in reduction in vacancy rate for band 5 roles from 18.7% (August 2018) to 14.4% (January 19). It is predicted that the vacancy rate will increase slightly in Q1-2 whilst awaiting staff to complete programmes of training. 181 nurses and midwives are progressing through recruitment checks. 50% of these are student nurses and midwives who will commence in post following graduation in September 2019. Over the last 12 months the annual Trust turnover rate for nursing and midwifery has improved. In January 2019 the rolling turnover rate was 13.2% (Shelford average 13.8%). The band 5 Nursing and Midwifewry turnover rate was 16.4% (national average 20.6%) The first group of 76 Nursing Associates will graduate between February and May 2019 and all have secured a substative position in the Trust. A Quality Impact Assessment (QIA) has been completed for the areas in which the Nursing Associates have been employed to mitigate against any risk associated with introducing a new role. There are 132 trainee Nursing Associates in training with the next cohort due to qualify in April 2020. The Trust will continue to recruit 120 trainees each year. The Trust continues to source nurses from overseas (India) through targeted overseas recruitment campaigns. The total number of International nurses recruited through the Trust's overseas recruitment campaign is 281 since December 2015. A total of 125 nurses have commenced in post since April 2018 with a further 75 nurses due before the end of June 2019. Monthly SKYPE recruitment also takes place to recruit nurses from India and UAE. This programme of work will continue in 2019/20. Programme of work to be introduced in March 2019 to support nursing establishment staffing reviews through the use of an evidence based tool. In January 2019 a Retention Workshop was held with the Hospitals and MCS Directors of Nursing and Human Resources Directors to agree a programme of work to continue to improve nursing and midwifery retention. Divisional sickness/absence reduction trajectories established with associated WAVE schemes.

Principal Risk: If the Group fails to demonstrate and evidence high quality standards consistently in the delivery of care, leadership and use of resources then the organsation may fail to achieve appropriate ratings from regulatory bodies (5447C)	Enabling Strategy	Associated Committee
	Quality and Safety Strategy / OD&T Strategy / Transformation Strategy	Quality and Safety Committee
	Lead Director	Operational Lead
	Medical Director / Chief Nurse	Director of Clinical Governance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	Reputational impact Associated business continuity	SHINE Oversight Group Executive Leadership Regulatory Engagement Meetings Organisational Governance Structure Self Assessment Programme Organisational self assessment Policies & Procedures Pathways Values & behaviours Ward accreditation programme	16 4x4	Self assessment has proven to be unreliable.	CQC Comprehensive Inspection Report now >12 months old Well-led assessment not yet undertaken Use of resources assessment not yet undertaken	Group and Hospital Governance arrangements Board Assurance Framework CQC Insight Report - currently no overall rating available Board of Directors Reports Internal / External Audit Patient and Staff surveys External Visit Data CQC internal monitoring CQC relationship meetings IQP data Clinical quality metrics Accountability Oversight Framework data	CQC Comprehensive Inspection Report Nov 15 and January 16 Quality Review reports 2016 Deanery and GMC training survey	9 3x3

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Governance arrangements Report reciept Report response	Sarah Corcoran	Feb-19	Quality and Safety Committee	Movement to a CQC rating of 'outstanding' or 'good' across all services Compliance / appropriate ratings across all other external regulation	MFT has in place agreed clinical and other governance structures to ensure that evidence of the high quality, evidence based safe care and the 'well-led' requirements can be met. A comprehensive inspection has been undertaken and a draft report recieved. The report has been checked for factual accuracy and returned with comments.

Principal Risk: If patient care is not delivered to a high level of safety and quality patients could be harmed, staff could be harmed, the organsation could fail to meet regualtory standards and reputation would suffer.			Enabling Strategy: Quality and Safety Strategy / OD&T Strategy / Transformation Strategy			Associated Committee: Quality and Safety Committee		
			Lead Director: Medical Director / Chief Nurse			Operational Lead: Director of Clinical Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 3x5	Poor patient outcomes Poor staff experience Failure to meet regulatory standards on quality and safety Reputational impact Associated business continuity	Organisational Clinical Governance Structure - including specialist functions such as Infection Control, VTE and EPR Board Accountability Oversight Framework Organisational self assessment Education and Training Integrated Governance System Policies & Procedures Pathways Values & behaviours Ward accreditation programme	**9** **3x3**	Self assessment has proven to be unreliable.	CQC Comprehensive Inspection Report now >12 months old	Board Assurance Report Accountability Oversight Framework Board of Directors Reports Internal Audit Patient and Staff surveys External Visit Data Internal Quality Review Reports CQC internal monitoring / Insight Reports IQP data Consultant metrics Clinical Audit Data - local and National Peer Review Processes	CQC Comprehensive Inspection Reports Nov 15 and Jan 16 in legacy organisations Quality Review reports 2016 in CMFT Legacy organisaiton Deanery and GMC training survey CQC Insight Reports	**9** **3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Comprehensive programme of work on communication of diagnostic and screening test results (Risk MFT/001701)	Sarah Corcoran/Gill Bell	See Risk Register for detail	Informatics Strategy Board	10% reduction in harm	See risk register
Comprehensive programme of work on never events (Risk MFT/001671)	Sarah Corcoran		Infection Control Committee		
Comprehenisive programme of work on meeting all infection control standards (Risk 1970 MFT/001123)	Andy Dodgeson / Julie Cawthorne		Medicines management Committee		
Comprehensive programme of work on the management and quality of the health record (Risk MFT/000359)	Sarah Corcoran / Gill Bell		Informatics Strategy Board		
Comprehensive programme of work on Medicines Management and Security (Risk MFT/000218)	Charlotte Skitteral		Quality and Safety Committee		
Comprehensive programme of work on Orthopaedic Services Review (Risk MFT/001873)	Mandy Bailey / Richard Montague		WTWA Quality and Safety Committee		
Comprehensive programme of work on neonatal transport (Risk MFT/000236)	Karen Connolley		Saint Mary's Quality and Safety Committee		

Principal Risk: Availability and Management of Patient Records Risks 5045C/MFT/000359/5300U			Enabling Strategy				Associated Committee Group Informatics Strategy Board	
			Lead Director Group Chief Finance Officer				Operational Lead Group Chief Informatics Officer	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Patient Harm as a result of inaccessibility of case notes Reputational Damage arising from poor quality data. Inadequate assurance on quality of care. Financial and reputational damage arising out of failure to meet regulatory quality standards such as CQC. Financial damage resulting from inaccurate coding	Oxford Road Campus (ORC): Best Practice Standards for Records Management in place & achievement of the standard monitored through a suite of KPIs which improve availability at point of need. Improve visibility of electronically captured patient information by providing access through one system. Creation of Case Notes reduced to 5 areas and the PAS district number has replaced the maually allocated case note number for ORC, to become the unique identifier in the system. Clinic preparation for ORC has moved to ORC Health Records Hub 3rd Floor RMCH. New sets of case notes now labelled with barcodes to faciliate tracking. Obstetric notes will be retained in the Health Records Hub (3rd Floor RMCH) from Sep 2018. Commencement of Terminal Digit Filing within the Gorton Library. Performance Indicators now being presented to the Group Information Governance Board.	16 4x4	Best Practice Records Management Standards not followed Full KPI suite not yet embedded into operational practice Full EPR not in place	Accuracte tracking of the location of the case note.	Accurate monitoring and identifying issues in place and reporting to the Group Information Governance Board.	Health Records Improvement Programme in place and funded reporting to formal Group Informatics Governance Board.	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Significant progress made on a range of Actions completed 2017/18. Continued tactical development of EPR in place to for 2018 -2020 and procurement and full implementation of new EPR solution. Ongoing implementation of best practice standards for records management implemented through Health Records Improvement Programme. Further Business Case approved to facilitate the turning of the whole library to Terminal Digit Filing. Patient Records campaign on what is a patient record and promoting the use of the electronic systems has commenced. Work programme commenced to scan loose filing and surface the images in Chameleon. Deployment of scanners to improve tracking of case notes is planned over the next month. Commenced review of the impact to patient experience when the case note is missing and evidence of harm.	Director of Digital Delivery	On-going	Group Informatics Strategy Board (Performance Indicators on availability are monitored at the Group Information Governance Board which is chaired by the Group CIO)	Best Practice Health Records Standards in place.	

Principal Risk: Cyber Security Risk - Trust IT Risk: MFT/000363			Enabling Strategy				Associated Committee Group Informatics Strategy Board	
			Lead Director Group Chief Informatics Officer				Operational Lead Group Chief Informatics Officer	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 5x3	If there are malicious attacks to IT system, vulnerabilities could compromise or disable access to systems and or data. Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm and patient experience adversely impacted (e.g. wait times increased) as well as Financial & reputational damage.	Appropriate Controls are in place to manage the threat of cyber attack and other IT vulnerabilities and security threats.	15 5x3	Reguar reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	Emerging Cyber Risk may mean gap in assurance through non-availbility of specialist knowledge at point of risk.	Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	All agreed actions carried out in line with approved plan timescales.	**12** **4x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. Additional improvements have been carried out and Cyber Essentials pluss action plan updates submitted to NHS Digital for ratification.	Group Chief Informatics Officer	on -going	Group Informatics Strategy Board	Minimise risk to the Trust.	

3	**Strategic Aim:** To improve the experience of patients, carers and their families

Principal Risk: If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public	**Enabling Strategy**	**Associated Committee**
	Safe operation of the site infrastructure	CEO Forum
	Lead Director	**Operational Lead**
	Chief Operating Officer	Group Director of Estates & Facilities

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
15 3x5	Loss of operational area(s) and potential impact for harm to staff, patient of public	Detailed business continuity plans to mitigate the impact of any failure Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system). Agreed maintenance regimes to ensure the infrastructure is maintained to the required level External reviews of systems and processes to highlight gaps and required actions	15 3x5	Not all maintenance regimes have been adhered to and not all infrastructure schematics accurately represent the 'as built' estate Some controls are reactionary, based on minimising impact should an issue occur	Time taken to complete external reviews and surveys & undertake any required remedial works	Ongoing survey and audit reports to reduce level of unquantified risk and support that adequate controls are in place. Expert analysis of risk as developed through Trust and independent experts to confirm the adequacy of the controls	Ongoing certification of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects Focus remains on key clinical areas for remedial actions	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Complete the ongoing survey works across all sites Complete all remedial works across the sites	Director of Estates & Facilities	Jun-19	CEO Forum	Survey work completed & remediation carried out	Survey and remediation work on track with the exception of electrical infrastructure on the Oxford Road site. Further work ongoing with ProjectCo and Sodexo to address this

Principal Risk: If we do not have an embedded transformation programme we will not be able to deliver the clinical integration benefits and improve the experience and services for patients at the scale and pace required	**Enabling Strategy**	**Associated Committee**
	Transformation strategy /Quality Strategy/OD&T Strategy	Transformation Operational Board
	Lead Director	**Operational Lead**
	Chief Operating Officer	Group Chief Tranformation Officer & Deputy Group COO

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
6 **3x2**	We do not deliver improved quality, experience or the financial savings. We will not deliver sustainable change at the pace and scale required.	Transformation annual plan approved by BODs with quarterly progress report to TMB and BODs Monthly Divisional Reports Monthly Transformation Operational Board Updates to Quality Committee & Finance Scrutiny Committee Quality Gate Reviews PMO Governance Process PIDs with KPIs and measurements	**6** **3x2**	Lack of upto date benchmarking information to assess against peers and identify/assess areas for opportunities. Ability to routinely measure progress against SAFER, elective and outpatient standards as data is not automated.	Membership of Dr Foster tools reduced. Work ongoing with informatics to ensure meansurement.	Shelford Transformation Network used to benchmark specific measurements Contribute to NHS Benchmarking Projects Annual Trust Capacity Tool designed to benchmark through HES data Get It Right First Time programme	n/a	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Group: Implement complex integration projects to deliver clinical and financial benefits Hospital / MCS: Embed SAFER, elective and outpatient standards	Chief Transformation officer CEOs	31/12/2019	Operations and Transformation Oversight Board	Standards to become business as usual	Updates on progress presented to Quliaty Committee.

Principal Risk: If appropriate systems and processes are not in place to support End of Life Care this could result in poor experience for patients and their families approaching end of life and variation in service delivery (Risk 4548)	Enabling Strategy: Palliative and End of Life Strategy 2016-2018	Associated Committee: Adult Palliative and End of Life Group
	Lead Director: Chief Nurse	Operational Lead: Director of Nursing, MREH/UDHM (EoL Care Lead)

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	Variation in the levels of assurance which can evidence the delivery of End of Life Care across the different models across the Trust Risk of poor experience for patient's and their family approaching the end of life	1.Executive lead for End of Life care - Chief Nurse, who chairs Executive Oversight Group. 2. Reporting and governance structure implemented and in place, governance harmonisation commenced from June 2018 from to drive improvements across MFT. 3. Adult Palliative and End of Life Group and Babies, Children and Young People End of Life Group chaired by clinical leads. 4. Palliative and End of Life care strategic plans and work programmes delivered through respective groups, overseen by Executive Oversight Group. 5. Implemented Adults Priorities of Care for the Dying Person care plan to support evidence based care delivery for patients and families, audit programme in place. 6. Single MFT standard developed for End of Life Care. 7. Policies and guidelines available through the Specialist Palliative Care website to support evidence based quality end of life care. 8. Appointment of x 1.8 Consultants to provide 7 day palliative service for ORC Adult patients. 7 day palliative care nursing service in place on ORC. RMCH Palliative Care Team in progressing. 9. Participating in the NHS England programme, Transforming EoLC in Acute Hospitals Programme. 10. EoLC care plans are based on NICE guidance.	4 2x2	None	1. Audits of adult EoLC delayed whilst policies were harmonised and education and training provided. Trust-wide audit planned for April 2019.	1. Palliative and End of Life Care Strategy including Children, being revised as part of harmonisation process. 2. Reports to the Quality and Safety Committee from Palliative and End of Life Work Groups delivering related work programmes. 3. Updates to Risk Management Committee, with risk reduced in May 2016 to 3x3 = 9 then to 2x2 in August 2018. 4. Working Groups work programmes monitored through the End of Life Oversight Group to ensure delivery of actions. 5. 7 day adult palliative care nursing and consultant service implemented in June 2017 on ORC and already established for WTWA. 6. Implementation of 'Comfort' observations for patients receiving EoLC across ORC and identified wards at WTWA. 7. Participation in National Transformation programme ACP and Rapid Discharge. 8. Participation National Dying Matters Week across all hospitals. 9. NHSI/NHSE Supportive Review Visit in July 2018, positive feedback with areas of harmonisation work identified.	1. Audits demonstrating improvements in the delivery of care of the deceased person and compliance with EoLC care plan standards. 2. Care of the Deceased Policy harmonised and changes to practice implemented across the Trust. Education programme designed and will be launched in March 2019. 3. Results from 2018 National Audit of Care at the End of Life Care received in February 2019 and demonstrate good compliance with standards. 4. Hospital/MCS EoLC work plans integrated with EoLC clinical review standards, which are used by divisions within each hospital to measure palliative and EoLC practice quarterly. Action plans are developed to supoprt continuous improvement. 5. Completion of SHINE EoLC reviews during 2018.	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Implementation of End of Life Strategy and work programmes Development of mechanisms to gain feedback from families in relation to end of life care	Sue Langley, Director of Nursing	Q4 2018/19	Quality and Safety Committee	Assurance that EoLC is consistently high quality and evidenced based across all care settings	1. Work programmes progressing in line with expected delivery dates. Adult services reviewing potential service models with SHS team. 2. Adult and children's bereavement services have separated and are now located with the adult bereavement centre and in RMCH respectively. 3. Bereavement Leads identified for all Hospitals, MFT bereavement group established with representation from adults and children's services, chaplaincy, ED and Admission Wards 4. Staff survey related to bereavement knowledge/skills undertaken. Results currently being analysed. 5. Wwhen someone dies' booklets have been developed/updated with site specific information i.e coroners numbers, bereavement centre numbers. 6. Adult EOLC group meetings are held on alternate sites with senior staff attendance. 7. Cross site collaboration to develop/deliver education and training programmes relating to new policies. 8. Plan developed to harmonise the use of needleless devices for T34 infusions 9. Collaboration in place to ensure good EOLC cover at Trafford Hospital. 10. Plans in place to commence the Care Of Dying Experience adult bereavement survey-across the Hospitals. 11. Work ongoing to harmonise use of the EoLC symbol across ORC/WTWA. 12. Matron Post for Palliative and EoLC introduced at RMCH, Family Liaison post introduced in Paediatric Critical Care.

Principal Risk: If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation			Enabling Strategy Quality and Safety Strategy Lead Director Chief Nurse			Associated Committee Quality and Safety Committee Operational Lead Corporate Director of Nursing		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Adverse patient experience Damage to the Trust reputation Failure to comply with regulatory standards	1. Corporate and hospital/MCS/MLCO Quality governance and delivery structures. 2. Patient Environment of Care Group supported by relevant expert groups oversees delivery of work programme and monitors impact through patient feedback mechanisms. 3. Contract monitoring focused on patient experience outcomes. 4. Monitoring and reporting systems in place for complaints, concerns and compliments. 5. MFT Compliments, Complaints and Concerns Policy ratified by Quality and Safety Committee in place since 2018. 6. Complaints management guidance provided to Hospitals/Managed Clinical Services. 7. Complaint response performance monitored within agreed timescales and performance regarding over 41 day complaints cases monitored through AOF. 8. Improving Quality Programme in place across the Trust. 9. What Matters to Me Patient Experience programme established. 10. Accreditation programme in place across the Trust.	**6** **3x2**	1. Patient experience programme - What Matters to Me - still embedding across Wythenshawe and Withington Hospitals.	1. Scores are below average for food and aspects of discharge in national inpatient survey (2017).	1. Reports to Quality & Safety Committee. 2. Performance reporting to BoD and Quality and Performance Scrutiny Committee. 3. Internal and external Patient survey results. 4. MFT Quality Care Rounds and WMTM (Patient Experience) survey data. 5. Joint audits of compliance with standards with Sodexo. 6. Accreditation outcomes. 7. Outcomes of the Quality Reviews reported to Board of Directors. 8. Harm free care data monitored and reported through Hospital/Managed Clinical Service governance systems and to Professional Board. 9.Reports to the Board of Directors and its sub-committees on progress and results of the Accreditation Programme. 10. External reports such as CQC assessment. 11. Friends and Family Test data. 12. Reports to Professional Board.	1. Improvements in care evident from Quality Care Rounds and Patient Experience survey data. 2. Accreditation outcomes 3.Senior Leadership Walk rounds 4. Outputs from Bee Brilliant programme	**6** **3x2**

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Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Embed Patient Experience Framework - WMTM across MFT Deliver Dining Action Plan Deliver Environment of Care Group work programme	Hospital Directors Deputy Chief Nurse and Assistant Chief Nurse (Quality, Professional Practice and Cancer)	Mar-18	Quality and Safety Committee	Improve areas of patient experience that consistently score below average in national patient surveys	MFT Quality and Safety Strategy ratified by BoD in July 2018 following recommendation by Quality and Safety Committee. Good engagement with, and spread of What Matters to Me (WMTM) approach to patient experience - from staff and patients. Development and extensive delivery of WMTM Masterclasses for staff across the Trust. First Impressions course developed and delivered for administrative. Ongoing improvement plan for food and nutrition. Draft Nutrition and Hydration Strategy completed for ratification by Quality and Safety Committee and launch in national nutrition and hydration week (9th March 2019). Two FM Matrons in post on Oxford Road campus and two FM Matrons in post for WTWA (FM Matron Team total 4wte) enabling dedicated leads for food/nutrition and environment and supporting areas with dining and environment. The percentage of patients who indicate a positive experience in response to Quality Care Round survey questions about food and nutrition continues to exceed 90% across MFT against a target of 85%. Annual review of Quality Care Round and What Matters to Me (Patient Experience) survey questions undertaken. MFT accreditation programme completed in February 2019. IQP roll out programme for Wythenshawe Hospital progressing with dedicated resource based at Wythenshawe Hospital. Corporate support provided to MRI since September 2018 to improve response, quality and timeliness of complaints. Patient experience/complaint reports developed at Hospital/MCS/ level.

Principal Risk: If there are insufficient trained mental health support this could impact negatively on patient outcomes and experience (Risk 4140C)			Enabling Strategy			Associated Committee		
			Quality and Safety Strategy			Quality and Safety Committee		
			Lead Director			Operational Lead		
			Medical Director			Director of Clinical Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Poor patient outcomes Poor patient experience	Safeguarding Team Policy guidance on the Mental Health Act specifically Guidance on the Mental Capacity Act Training to ensure clincal understanding on quality of care Mental Health Nurses Mental Health Act Manager Staff expertise Specialist recruited to review	9 3x3	Formalised arrangements for Psychiatric Liason support	Lack of qualititative data on services	Clinical audit Patient feedback External review	None	6 3x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Working with Greater Manchester Mental Health Foundation Trust and Manchester CCG have formalised arrangements. Support funded and recruited to maintain progress in year Group governance structure now established	Sarah Corcoran/Sue Ward	Mar-18	Quality and Safety Committee	Support available to patients and staff when needed	Sitle level meetings now in place for the larger sites Policies drafted and in some cases approved

4	Strategic Aim: To achieve financial sustainability

Principal Risk: If the Trust fails to consolidate financial recovery achieved by CMFT/UHSM and /or to meet further annual efficiency challenges as these arrive then the Trust may not be financially sustainable.	Enabling Strategy	Associated Committee
	-	Finance Scrutiny Committee & Risk Management Committee
	Lead Director	Operational Lead(s)
	Chief Finance Officer	Hospital Finance Directors

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 5x4	Breach of Control Total leading to loss of Sustainability Funding would significantly jeopardise the ability to invest in and sustain improvments for patients	1. 2019/19 Control totals at hospital/MCS level have been agreed at Finance Scrutiny Committee (FSC) on 5/9/18 2. Hospital/MCS forecast for months 6-9 have been reviewed and challenged by CFO/GDoF 3. FSC has reviewed progress against control totals both YTD and Months 6-9 forecasts at a hospital/MCS level on 5/9/18 4. CEO and DoF of MRI have presented plans and progress update against their delivery plan at FSC in March, September 2018 and januray 2019 5. Hospital/MCS' with deficit Control Totals have provided first outlines of plans to complete recovery to breakeven within one or two year period as appropriate 6. Hospitals assessments of 2018/19 exit run rates and 2019/20 delivery challenges will be reviewed by FSC in March 2019. 7. All delivery plans continue to benefit from structured Quality Impact Assessments at Hospital/MCS, which are further QA'd at Group level	20 5x4	None	None	Each month the Hospitals/MCS are assigned an AOF rating against the finance domain based on their performance, which determines the level of prorress recognised, intervention and support required	An extensive framework of review, challenge and escalation is fully embedded within the organisation	**12** **3x4**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring	Planned Outcome	Progress Evaluation
Sustained delivery against forecast trajectories remains critical to risk reduction. Progress against delivery will be examined at Finance Scrutiny Committee.	Hospital Leadership Teams	Monthly	Finance Scrutiny Committee	-	-

Principal Risk: The Trust remains at a lower level of digital maturity than its ambition in order to support Trust strategy. Risk: MFT/000920			Enabling Strategy New Strategy to be confirmed. Lead Director Group Chief Informatics Officer			Associated Committee Group Informatics Strategy Board Operational Lead Group Chief Informatics Officer , Corporate Directors and Hospital CEO's		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Trust remains at a lower level of digital maturity than its ambition, impacting on delivery of benefits, patient care and reputation	Monitoring of * Delivery of Informatics Plan. * Benefits Realisation - Qualitative and Quantitative. * Digital Maturity index for Trust. * Integration Steering Group monitoring of Informatics PTIP Plan. * Strategic Business case approved. * Procurement has commenced for strategic EPR solution. * Trust Board EPR Task & Finish Committee has been established for Gateway Approval	**6** **3x2**	Change in external landscape	The significant workload to understand the landscape of the 2 organisations and the planned programmes of work.	Introduction of SHS Informatics Governance in 2018/19 Group Management Board approval made in January 2018 to go to Open Procurement for an EPR.	Monitoring against HIMSS digital maturity Index. Regular updates to Hospitals and Group. Informatics Membership on Boards. Informatics PTIP Reporting	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Robust Monthly Monitoring against plans Good development work with both EPR Tactical Business cases going through the approval process. EPR Innovation Council implemented. HCCIOs appointed. New MFT Informatics Strategy Approved by GISB and progressing through Trust governance.	Group Chief Informatics Officer	Monthly	Group Informatics Strategy Board	Achieving priority	as per controls

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals

Principal Risk: There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.			**Enabling Strategy**			**Associated Committee**		
			Group Service Strategy / Clinical Service Strategies (in development)			Board of Directors		
			Lead Director			**Operational Lead**		
			Executive Director of Strategy			Informatics , Corporate and Hospital/MCS CEO's		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
9 **3 x 3**	Loss of service leading to reduction in range of services offered within GM and, as an impact, loss of income, damage to reputation, loss of staff and reduction in research opportunities.	Involvement in the GM Partnership forums to provide a united voice on maintaining GM-based services. Involvement in strategic clinical networks Regular discussions with NHS England Medical Director Representation through the Shelford group Active involvement in Operational Delivery Networks Regular meetings with NHSE North established	**6** **3 x 2**	Management capacity within corporate team to identify ongoing risks and issues against each of the our specialised services (as flagged through quality surveillance reviews)	Development of regional planning boards for specialised services (NHS Long Term Plan) - unclear how these will affect further reconfiguration discussions	Outcome of quality surveillance reviews	Status as largest provider Trust and with highest proportion of specialised services nationally Ability to offer co-located services Award of national tender for Auditory Brainstem Implantation - one of only two providers in the country	3 3x1

Key Actions	**Responsibility**	**When**	**Monitoring Committee**	**Planned Outcome**	**Progress Evaluation**
Completed the annual surveillience reviews across ORC and Wythenshawe sites and have made overall assessment of areas of compliance across the Group.	Strategy Team	Jul-18	Group Management Board	Have a trust wide view of compliance across all specialist services.	Completed
Work through areas of non-compliance with hospitals and MCSs as part of annual planning.	Strategy Team	Mar-19	Group Service Strategy Committee	All hospital and MCS annual plans for 19/20 will include plans for addressing compliance issues in specialised services.	Scheduled
National specialised services under review by NHSE to be analysed and individually risk rated by the strategy team as part of the corporate team's regular risk management process. This will identify specialised services viewed as being most vulnerable to consolidation away from MFT.	Strategy Team	May 18 - March 19	Group Service Strategy Committee	Risk rated list of specialised services under NHSE review for prioritisation and further action.	In progress
Maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews	Strategy Team	Ongoing	Group Service Strategy Committee	Strategy team to remain informed regarding NHSE clinical service review priorities and timescales	Ongoing

Principal Risk: The decisions made through the Greater Manchester governance structure do not align with MFT's plans for service development.			Enabling Strategy			Associated Committee		
			Taking Charge - Manchester Stategic plan			Board of Directors		
			Lead Director			Operational Lead		
			Executive Director of Strategy			Group Directors, Corporate Directors, Hospital/MCS CEOs		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
8 **4x2**	Mis-match between MFT and GM plans. Loss of united GM voice.	MFT representatives on GM boards such as the Health and Care Board, Partnership Executive Board, Provider Federation Board, Chairs' group, HR, Directors of Finance, Directors of Strategy, Directors of Ops, JCB Executive Group etc. MFT representatives on Theme 3 Board, Theme 3 Executive, Theme 3 Clinical Reference Group PFB enables providers to engage as a group with GM Devolution Process in place for GM decision making which involves and recognises the Trust's decision making requirements Development of MFT clinical service strategy, taking GM decisions into account and forming coherent strategies for the Trust.	**6** **3x2**	Voting structures are based on majority voting (75% majority) with a single vote for each stakeholder group (NHS England, local authorities, CCGs, providers).		Reconfiguration of Theme 3 services aligned with MFT aims Theme 4 changes aligned with MFT aims	MFT designated lead provider for specialist emergency care and emergency general surgery (Healthier Together) MFT (Wythenshawe) designated lead provider for urology cancer surgery (Theme 3) MFT designated lead provider for Haematological Malignancy Diagnostics Services across GM GM PACS procurement in alignment with MFT aims Theme 3 options	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continual attendance by Chair, Chief Exec, Director of Stategy and Medical Directors at GM meetings, fully briefed by strategy team	Strategy team	Ongoing	Board of Directors	Ongoing ability to ensure that GM and MFT decisions are aligned	Ongoing
Develop the MFT clinical service strategy and underpinning service level strategies taking GM decisions as fixed points.	Strategy team	Q1 2019/2020	Group Service Strategy Committee	A MFT clinical strategy that reflects GM decisions and develops an appropriate strategic vision and plans for the Trust, underpinned by detailed strategies for groups of services.	In progress

Principal Risk to Key Priority: If there is a lack of clinical buy-in this could impact negatively on the achievement of single services			Enabling Strategy			Associated Committee		
			Transformation Strategy and Leadership and Culture strategy			SHS Programme Board		
			Lead Director			Operational Lead		
			Joint-Medical Director			Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
6 **3X2**	Failure to achieve clinical buy-in could mean that although the Trusts technically become a single organisation, the clinical staff do not work together and become single teams functioning as single services.	Clinical engagement sessions held in early phases of review that led to the recommendation of SHS in order to increase collaboration across Trusts Appointment of clinical leads for standards groups Clinical engagement in development of clinical services strategies Clinical engagement in development of single service models for individual specialties Creation of clinical structure for SHS that facilitates collaboration across sites and agreement on single service models Clinical Advisory Group established. OD programme in place Operations and transformation working group established that incorporates OD elements Appointment of Joint Medical Directors to Board Clinical representation on the Values and behaviours steering group	3 3x1	Feedback that key information and messages relating to the new organisation are not being cascaded fully to clinical teams	History of failed attempts at collaboration. No routine mechanism to assess attitude to merger	Lessons learned from previous service mergers Results of next quarterly staff online pulse check surveys.	Positive feedback on values and behaviours work through ACE day cascade. Feedback from engagement events (SHS updates to BoD) Level of clinical involvement in events and strategy development Areas where clinicians are already working together - cardio-respiratory, urology (theme 3), vascular (theme 3), Progress with Healthier Together (SD update to BoD) Medical engagement scores in Staff survey and where possible pulse checks. Clinical staff have been involved in shaping the new organisational values and behaviours Senior clinicians are included in the new organisational values video In Q1, 68% (+4% on Q4) of medical staff agreed that they had frequent opportunities to show initiative. 73% of medical staff agreed that they were able to suggest improvements in their area of work (+8%). 52% of medical staff reported that they were able to implement improvements (+1%).	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Values and behaviours work shared and discussed via quarterly ACE days and poll	OD team and divisional management teams	End Sept - start nov	SHS Programme Board	Development of the right culture and behaviours to deliver the Trust's strategy in the new organisation.	Completed
Information and messages relating to the merger shared with newly qualified consultants as part of the NACs programme.	OD team and Medical Directors	12th October	SHS Programme Board	Continued staff awareness of and engagement in activites relating delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Staff engagement events with briefings from the Chief Executive	Communication team	September to October	SHS Programme Board	Continued staff awareness of and engagement in activites relating delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Staff engagement sesssions led by Executive Directors	OD team	Tranche 1: August - September Tranche 2: October - November	SHS Programme Board	Continued staff awareness of and engagement in activites relating to delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Delivering tailored support to 27 teams that make up the 'Operational and Transformation project list'	OD, transformation and SHS teams	Ongoing	Transformation & Operations Oversight Committee	Rapid delivery of benefits relating to the merger.	Ongoing and aligned to clinical strategy development
Opportunity provided to share and discuss values and behaviours work with all staff during NHS Change week	OD team	Week commencing 13 November	SHS Programme Board	Development of the right culture and behaviours to deliver the Trust's strategy in the new organisation.	Completed
Circulate enabling strategies (Transformation and Leadership and Culture) during NHS Change week	OD and transformation teams	Week commencing 13 November	SHS Programme Board	Awareness of and engagement in implementing strategies for delivering benefits of the merger.	Completed
Values and behaviours framework developed by hospital leadership teams to be approved at GMB (May 2018)	OD team	21st May 2018	Workforce & Education Committee	MFT values & behaviors framework to support the development of the organisation's culture	Completed
New timetable of CEO Staff Engagement Events	Communication team	6 Monthly	Workforce & Education Committee	Supporting staff - listening and continuing engagement, encouraging creativity	Ongoing

6	Strategic Aim: To develop our research portfolio and deliver cutting edge care to patients

Principal Risk: If there is a failure to secure Genomic Laboratory Hub designation then there could be loss of staff, reduced income and an negative impact on reputation	Enabling Strategy	Associated Committee:
	-	Group Service Strategy Committee & Research Effectiveness
	Lead Director:	Operational Lead:
	Joint Medical Director	CEO - Saint Mary's Hospital

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
5 5x1	Risk to clinical income. Loss of key clinical academic staff. Impact on research standing. Weakens Precision Medicine proposition. Loss of commercial opportunities.	Genomics Division Leadership Team GLH Leadership Team Saint Mary's Management Team North West Genomics Strategic Partnership Board	**10** **5x2**	*(Redacted - Commercially sensitive)*	*(Redacted - Commercially sensitive)*	*(Redacted - Commercially sensitive)*	Bid to secure GLH status submitted with the written support of relevant external partners. *(Redacted - Commercially sensitive)*	5 5x1

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
(Redacted - Commercially sensitive)	1. Genomics Division Leadership Team	1. 2019 Q1	1. Saint Mary's Hospital Management Board	(Redacted - Commercially sensitive)	(Redacted - Commercially sensitive)

7	**Strategic Aim:** To develop our workforce enabling each member of staff to reach their full potential.

Principal Risk: If the OD Strategy and therefore a high performing, inclusive and values based culture that increases organisational resilience and agility and City of Manchester system leadership and integration (LCO) is not implemented then quality, safety and patient experience may be compromised.	**Enabling Strategy**	**Associated Committee**
	OD Strategy	HR Scrutiny Committee
	Lead Director	**Operational Lead**
	Executive Director of Workforce & OD	Group Deputy Director of Workforce & OD

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 **3x4**	1. Insuffient number of high calibre leaders for business critical roles 2. Poor culture (including leadership) undermines Trust performance 3. Unable to maximise the organisational opportunities offered by the Manchester Transformation agenda 4. Low functioning teams impacting on the quality of care 5 Poor staff engagment and therefore low advocacy and impact on patient care	Deputy Group Director of Workforce and OD lead and set clear objectives for OD&T team Leadership and Culture Strategy and implementation plan approved Appraisal policy in place and quality standards monitored Hospital/MCS Workforce Plans in place Accountability Oversight Frameowrk with KPIs to measure performance Hospital/MCS Directors of HR & OD and team in place to support local Managers and Leaders. Leadership and improvement programme in place Programme to build effective teamworking in place	**9** **3x3**	1. No Systematic Values Based Recruitment process 2. No Talent Management and succession plans	1. No Systematic application and monitoring of a talent management process. 2. Not testing systematically values at recruitment 3. Poor HR I.T. systems to support monitoring and lack of informatics expertise.	1. Accountability oversight framework 2. Staff engagement in hospital/turnaround and transformation programmes reported to Workforce and Education Committee, HR Scrutiny Committee and Transformation and Operations Oversight Committee 3. Leadership development outputs reported to Workforce and Education Committee, HR Scrutiny Committee and Transformation and Operations Oversight Committee 4. Speak Out campaign reported to Clinical Effectiveness Committee 5. Appraisal training -Workforce and Education Committee & HR Scrutiny Committee 6. Pulse Checks results reported into WEC and HR Scrutiny Committee	1. Above national average for Staff Engagement 2. Above the national average for staff advocacy rates 3. Staff attendance on leadership and management programmes 4. 90 % compliance with appraisals 5. Transformation Case studies and assurance reported to the Operations and Transformation Group 6. 90% compliance with Clinical Mandatory training 7. 90% compliance with Corporate Mandatory training 8. Assurances for all of the above are reported to HR Scrutiny Committee and Trust Risk Committee	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1 Review revised Corporate Induction following particpant feedback 2. Review and Develop new Appraisal policy and paperwork 3. Implement Values and Behaviours programme 4. MFT Excellence Awards 5. Staff survey report and plan 6. Leadership and Improvement capability programmes 7. Emebedding the Affina Programme 8. Secure investment from Transformation fund for implementation of intergration OD plans	HR/OD&T	Mar-19	Workforce and Education Committee and HR Scrutiny Committee	Maintain the 2017 response rate to Staff Survey Improve Staff engagement score to above average Number of key findings in the staff satisfaction survey scoring above average increased	Values and behaviours Framework will be finalised and launched and programme for embedding values in place- Staff survey launched imporvements in reposnse rate and staff engagement scores- new Induction in place and evaluation ongoing- MFT Excellenec Awards completed and celebration event on the 8th March- Revised Leadership and Improvement offer in place and Leadership and Improvement Academy designed- 64 team coahces trained in Affina and over 60 teams activly involved- Transformation fund proposal submitted and awaiting decision.

Principal Risk: If the organisation is unable to deliver the best quality assured education and training then workforce capability and capacity, quality, safety and patient experience may be compromised.			Enabling Strategy			Associated Committee		
						Strategic Education and Workforce Committee		
			Lead Director			Operational Lead		
			Executive Director of Workforce & OD			Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	1. capability and capacity compromised- leading to poor performance and poor quality of care 2. Lack of flexibility to change and implement quality improvements 3. staff vacancies and diffucult to fill critical posts 4. high turnover 5. lack of innovation 6. Limited succession planning 7. Negative impact on Trust reputation	1. Learning and Education Policy 2.Induction and Mandatory Training Policy 3. Learning and Development Agreement 4. Education Quality Review process (Medical) 5. University, Deanery and GMC surveys 6. Leadership and Mangement Development Programmes 7. Apprenticeship Strategy in place 8. Workforce and Education Committee Established 9. Nursing and AHP Workforce Group	**12** **4x3**	1. Consistent and collective education and training evaluation process 2. Integrated Learning and Education Strategy 3. Lack of consistent and collective training needs analysis process 4. Workforce planning process not fully embedded 5. Unclear of impact of post bursery and education funding gaps	1. Assessment of quality of education and training provided by OD&T 2. Organisational Training needs analysis beyond mandatory training. 3. Development of national standards for Apprenticeships and impact levy spend	1. Cross professional learning and education monitored and reported to HR Scrutiny Committee via the Workforce and Education Committee 2. Apprenticeship programme monitoterd and reported to the Apprenticeship Steering Group and into the Workforce and Education Committee and HR Scrutiny Committee 3. Medical Education Board 4. GM Nurse Associate Partnership and PMO 5. individual professional risk registers 6. Healthcare Science Workforce Group	1. Meeting our staff retention targets 2. Above the national average for staff engagement and learning development as part of staff survey results 3. 90% compliance with Mandatory training 4. Meeting our apprentice starter target 5. Student/trainee feedback 6. GMC Surveys and benchmarks 7. Accreditation and accredited services 8. 100% of Appreciceship and Levy committed.	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
• Deliver an active and engaging Widening Participation Programme • Expand and develop apprentice programme in line with national targets and MFT strategy • Deliver actions set out in the Talent for Care strategy • Develop an MFT integrated Learning and Education Strategy • Coordinate learning and education evaluation • Ensure that the positive aspects of and improvements made to the service are communicated to staff across the Group • The GM PMO programme of work around Nurse Associate and Graduate Nurses • Deliver the N & M Workforce Group programme of work	strategic aim 7	Mar-19	Newly establsihed Workforce and Education Committee and HR Scrutiny Committee	• Mandatory Training compliance at 90% • Achieve national target for new apprenticeship targets • To be above average (as compared to benchmark group) for all indicators relating to pledge 2 of the staff survey 'to provide staff with personal development, access to appropriate training and education to do their jobs and line management support to enable them to fulfil their potential • To be above the national average for staff enagement • Improvements in the Junior Doctors experience where this has been identified as a requirement by the GMC/Deanery survey	Continued to deliver supported internships and pre-employment opportunities through active involvement with schools. - Over 220 Nurse Associates in training , first cohort of 81 quaslify Feb 19 • 500 apprentices across a range of professions and 50% of levy spend committed • All potential apprentiship opportunities being scoped out via the Apprenticeship Steering Group • Talent for Care strategy actions implemented including improving learner facilities • Workforce and Education Committee operational • A new integrated Level 1 Mandatory Training programme developed and implemented since May . Compliance exceeding target at 91% • Process to produce MFT Education Stategy in development Learning Outcomes standards and 12 physcian associates rcruited and started.

Principal Risk: If there is a loss of funding for teaching for Undergraduate Education,(SIFT - Service Increment For Teaching) and/or changes made to the training programme by the University this could result in a reduced ability to fund the infrastructure required to deliver high quality education.			Enabling Strategy			Associated Committee		
			-			-		
			Lead Director			Operational Lead		
			Joint Medical Directors			Associate Director (Operational) Medical Education		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Impacts on the ability to fund the infrastructure required to deliver high quality medical education.	1. Close monitoring of income/spend 2. Reduced the overall cost of the service. 3. Prevent loss of further income	**12** **4x3**	Inability to influence the decisions made by the University re student placements	None	Monthly review of budgets with Divisional Accountant which forms the basis of a Divisional report shared with Senior finance officers . Comparison of reference cost, the results of	Feedback from yearly Student survey undertaken by the University, the results of which are sent to the Medical Director. Success rates for Medical exams	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Explore further options to reduce the cost of the service	G Terriere	Jun-17	Turnaround	Deliver 17/18 Trading gap	Achieved 01/04/17
Explore possibilities of increasing income	G Terriere	Jul-17	Turnaround	Possibility of Financial model to be introduced in 17/18	Initial discussion with Head of Medical school re amended funding model which would potentially increase the income to MFT. No further progress on this matter.
Explore possibility of increasing the number of students who undertake their projects at MFT	G Terriere	Jun-17	Turnaround	Increased student weeks and income	Increase in student numbers achieved which should be reflected in income for 18/19

Principal Risk: If there is inadequate focus on: workforce information and policies, workforce design and succession planning, attraction and resourcing; staff engagement; talent and performance management this may result in a negative working environment, loss of discretionay effort, productivity and high staff turnover / vacancies			Enabling Strategy: People Strategy Lead Director: Executive Director of HR and OD			Associated Committee: HR Scrutiny Committee Operational Lead: Group Associate Director of Workforce, Quality & Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **3x4**	Inability to attract, source and recruit the right numbers of skilled people aligned to our workforce plans and culture. High Temporary Staffing costs. Potential negative effect on staff morale, engagement and wellbeing. Inability to support the implementation of new service delivery models and maximise opportunities presented by the Manchester Transformation agenda. Increased potential for employee litigation as a consequence of TUPE/service change.	•Trust wide Workforce Strategy against 5 deliverables delivered through detailed HR work plan that is reviewed on a quarterly basis. Underpinned by KPI's that are reported monthly to GMB and BoD • Hospital/MCS workforce plans aligned to Business plans and the People Strategy. • Hospital vacancy control panel, agency and bank expenditure financial anlaysis and reporting and compliance with NHSI agency reporting requirements. Consistency panels for consultant recruitment. • Trust wide attraction strategy for all roles. International and domestic (Proud to Care) recruitment campaigns for nursing and other hard to fill roles. Consultant recruitment campaigns for hard to fill posts and joint attraction strateg for single hospital service including North Manchester General. • Operational HR service delivered through Hospital/MCS operational teams & specialist/transactional services at group level. Comprehenisve HR policy framework in operation under review. • Working in partnership with staff side to ensure positive employment relations culture. • Electronic job planning model introduced for medical staff with comprehensive training to support implementation and identified approach to team job planning. • Introduction of new Health & Wellbeing serivce model with development of Health and Wellbeing Strategy. • Development of a Workforce Technology strategy and delivery plan which encompasses all workforce systems including the development of an Electronic Workforce Intelligence Portal (EWIP) reporting model and HR portal supporting performance data analysis. • Apprenticeship Strategy supporting the delivery of new roles and career pathways, talent management and local community attraction across the whole workforce.	**9** **3x3**	Commitment to values based recruitment practice to strengthen selection processes across all staff groups. Capacity with both HR and line managers to deliver buisness as usual and transformational change. Impact of external market forces on hard to fill posts and agency supply and cost. Low control over actions of others within wider GM. Ongoing development and refinement of HR IT systems to support monitoring & people management	Fully embedding lessons learnt in future ER practice underpinned by inadequate case management reporting system. Maintaining attendance at 96.4% -	**Reported to HR Scrutiny Committee** Reduction in bank and agency. spend to cover sickness absence. Reduction in sickness absence rates. Staff Survey & Pulse Checks. Delivery of People Strategy deliverables. **Trust wide** Hospital reviews against Accountability Oversight Framework. Quality Reviews Speak Out campaign People and Development Performance Dashboard with Workforce KPIs NHSI Agency Caps reported on a weekly basis and data monitored for compliance **Reported to Strategic Workforce and Education Committee** Workforce plans	Key metrics delivered as reported in the Accountability Oversight Framework. Vacancies reduce by 5% (all staff groups) by March 2019. Time taken to fill vacancies achieved revised target of 55 days in Janaury 2019. Retention of staff with over 12 months service at more than 80%. Revised target set to 89% Maintaining attendance at 96.4% or better.	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Comparative assessment of HR IT solutions and systems between sites for HR areas of practice and development of visiosn for HR systems for the single hospital service. Continue to develop managers' competence and capability on people management issues. Further development of the HRBP model to support managers through the provision of advice, guidance and information. Ongoing development of workforce planning and data collection and analysis via ESR, including automation of operational processes to improve efficiency of service delivery. Further development of e-Wip and ESR to support the production of meaningful workforce intelligence including the launch of the HR Console for key performance metrics. Develop resources to equip the Trust to plan and implement organisational and system wide change, including development of a suite of HR tools to support collaborative management arrangements and integration. Delivery of attraction and recruitment campaigns using social media and engaging candidates strongly in the organisation at an early stage. Refresh of the Trust's Workforce Strategy (Q2/3) following integration of hospitals and evaluation of new HR model for delivery with resource, capacity and capability to deliver the Workforce strategy. Support to targeted work programmes for maintaining attendance with identified staff groups. Delivery of competence and values based selection processes on an incremental scale within current capacity and capability. Introduce modern approaches to attraction and selection that will enhance our position as an employer of choice in the market, both local, national and international. Review of consultant recruitment processes to enhance the candidate experience, revisit the investment proposal for nehanced consutlant recruitment processes and, if investment secured, consider the application of values based recruitment. Develop and implement the new employee health and wellbeing delivery model and strategy. Develop framework to integrate learning from employee relations cases.	HR/OD&T	Planned phased delivery throughout 2018/19	HR Scrutiny Committee. Governor Staff Experience Group Workforce and Education Committee	Compliance to Divisional and Trust sickness absence trajectories/targets Maintain the staff response rate (Staff Survey) to ensure it is either equal to or above the national average. To be above average (as compared to benchmark group) for all indicators relating to pledge 3 of the staff survey 'To provide support and opportunities for staff to maintain their health, wellbeing and safety'. Ongoing delivery of efficient and effective NHS compliant recruitment practice. Vacancy rates reduced to 5% through planned and coordinated recruitment campaigns and processes and the delivery of strong retention interventions. Agreed approach to managing workforce issues across integrated services supported by HR protocols and operational guidance. Clear understanding of health and social care workforce resource and development requirements. To achieve improvements in performance against key metrics as defined in the Workforce Strategy. Positive employment relations culture.	HR Work Plan18/19 The 2018 staff survey show improvements across 8 out of the 10 key themes with the final pre merger Pulse Check score (Q2 2017-18). The score for all three componets of engagement - advocacy, involvement in change and motivation all saw an improvement to their score. • Policy Development group established. Joint working with Trade Unions to produce single set of policies for MFT. • Workforce Technology strategy and delivry plan developed. Programme Board established to track and monitor progress • Engaged TMP to support with Attraction strategy and consultant hard to fill posts, campaign to focus on attraction and media platforms • Employee relations oversight group established to provide oversight, triangulation and analysis of cases and to learn lessons as appropriate • Developing revised AAC process for consultant recruitment • Temporary staffing programme board in development to oversee policy and process development Revised EHWB model being implemented

Principal Risk: If the Trust fails to meet statutory Equality and Diversity obligations then the perceived reputation of the Trust as an employer of choice may be negatively impacted upon. Trust risk numbers - 2503C/5378U			Enabling Strategy			Associated Committee		
			ED&I Strategy			HR Scruntiny Committee/Quality Committee		
			Lead Director			Operational Lead		
			Executive Director of Workforce & OD			Associate Director of Employee Wellbeing, Inclusion & Community		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 3x5	Negative financial impact and negative impact on MFT's Brand. Impacts ability to recruit the best staff	1. Governance reviewed to ensure clear accountability for ED&I 2.Year 1 action plan in place part of SHS programme management 3. KPI tracked at the board level on the retention and recruitment of BME staff 4. Systems in place e.g. WRES, EDS 2 and Equality Impact Assessments 5.AOF includes 2 metrics charting BME recruitment and retention	**12** **3x4**	1. MFT E&D Strategy not yet in place, due to be launch May 2019 as part of NHS E&D Week	1. Staff behaviour, whilst supported by clear HR policies and the Values programme will continue to be a risk for any employer aspiring to be a leader in the ED&I field. 2. Resource pressures on the Trust to deliver new mandated programmes by NHS England and HT/GM 3. Not all the ED&I data is robust with gaps in monitoring and quality for specfic protected characteristics 4. We are seeing a rise in patients being abusive to our staff with a focus on racist abuse 5. Accessibility Information Standard is not consistently embedded across MFT 6. Not all relevant Staff Survey indicators average or above.	1. Action plan in place for WRES, AIS and Year 1 deliverables 2. Issues regarding accessibility are reported and monitored as the Trust Accessibility Board 3. MFT E&D Governance agreed and being established 4. Managing poor behavriour programme 5. F2SU process developed. 6. Significant increase in EQIA's across the group.	1. No further high profile Employment Tribunals have taken place - monitored by the HR teams 2. CQC report outlined progress in ED&I 3. Removed off the EHRC watch list 4. BME staff retention meeting standard retention rate 5. Relevant Staff Survey indicators average or above	**9** **3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1. Deliver the actions as outlined in the E&D Action Plan. 2. Improve patient data through the Patient Profiling Working Group with Divisional Leads. 3. Improve workforce profile data through a campaign with colleagues. 4. Embed Equality Impact Assessments into all aspects of decision making. 5. Enhance the mechanism for staff to report incidents relating to ED&I through the Trusts systems, monitor and develop programmes to address key areas of concern. 6. Implement new BME leadership programme	Associate Dir EW,I&C	Apr-19	HR Scruntiny Committee	Reduction in patient complaints & Improvement is staff survey results	- Key metrics on staff and patient engagement - Embed pilot of trained BME managers on panel interviews for posts baded 8a and above - ED&I team redesigned to support delivery of group priorities - Workforce elements of E, D & I strategy in development following luanch workshop - Significant increase in workforce profile in relation to race equality

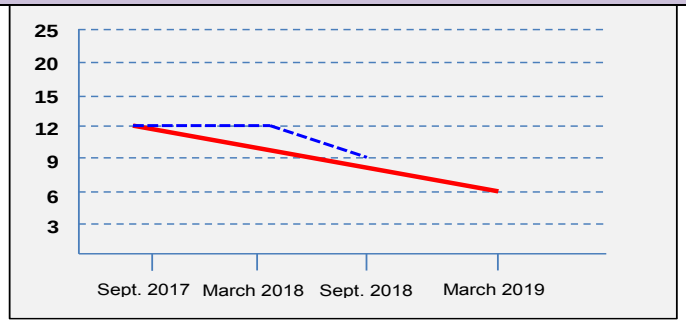
APPENDIX B

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

EXAMPLE

BOARD ASSURANCE FRAMEWORK (2019/20)

PATIENT SAFETY TEST

1	Strategic Aim: To provide high quality SAFE care	Risk Reference Number: *(Insert Here)*
PRINCIPAL RISK (What is the cause of the risk?): If the Quality and Safety Strategy is not delivered then harm may occur to patients	Enabling Strategy: **QUALITY AND SAFETY STRATEGY** Group Executive Lead: **JOINT GROUP MEDICAL DIRECTOR**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. Increase in serious harm to patients 2. Poor safety culture (including leadership) undermines Trust performance 3. Failure to eradicate 'Never Events' 4. Reputational damage because of safety concerns 5. Poor staff experience 6. Regulatory consequence	Associated Committee: **QUALITY AND SAFETY COMMITTEE** Operational Lead: **DIRECTOR OF CLINICAL GOVERNANCE** Material Additional Supporting Commentary (as required): *(Insert Here)*	***ILLUSTRATIVE TIMELINE GRAPH – TREND SUMMARY***

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
	Assigned Reference Numbers used for illustrative purposes only										
12 (3x4)	A1 XXXX A2 XXXX A3 XXXX A4 XXXX A5 XXXX A6 XXXX A7 XXXX A8 XXXX A9 XXXX	B1 XXXX B2 XXXX B3 XXXX B4 XXXX B5 XXXX B6 XXXX B7 XXXX B8 XXXX B9 XXXX B10 XXXX B11 XXXX B12 XXXX B13 XXXX	C1 XXXX C2 XXXX C3 XXXX C4 XXXX C5 XXXX C6 XXXX	D1 XXXX D2 XXXX D3 XXXX D4 XXXX D5 XXXX D6 XXXX	**9 (3x3)**	D2 XXXX B6 XXXX C5 XXXX B4 XXXX D4 XXXX D5 XXXX D3 XXXX B7 XXXX B13 XXXX D2 XXXX D4 XXXX C1 XXXX B3 XXXX	Medical Director's Team	March 2020	Quality and Performance Scrutiny Committee	1. Trust Compliance Officer appointed	**6 (3x2)**